



45350

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS**

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
City State Zip Code

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Medical Record Number: \_\_\_\_\_ Maiden or Other Name \_\_\_\_\_

**I hereby authorize (check center) or other Healthcare Provider (specify):**

Columbia University Medical Center  Weill Cornell Medical Center  Westchester Division  Other \_\_\_\_\_

**To release (check one)  Protected Health Information and/or  Sensitive Protected Health Information (see reverse side for definitions) pertaining to my:**

Hospital admission (date) \_\_\_\_/\_\_\_\_/\_\_\_\_  Outpatient visit (date) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Emergency Department visit (date) \_\_\_\_/\_\_\_\_/\_\_\_\_  Ambulatory/Outpatient admission (date) \_\_\_\_/\_\_\_\_/\_\_\_\_

**I authorize disclosure of the following information from my medical record (check where applicable list type and date):**

Immunization \_\_\_\_\_  Lab Reports \_\_\_\_\_  Radiology and imaging reports \_\_\_\_\_  
 Discharge Summary \_\_\_\_\_  Clinical Documentation \_\_\_\_\_  Pathology Reports \_\_\_\_\_  
 Other (describe) \_\_\_\_\_

**From my medical records to:**

Name of organization or person: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone (Area Code and Number): \_\_\_\_\_

**The purpose(s) for which disclosure is authorized (check where applicable):**

Medical Care  Insurance  Immunization  Other (specify) \_\_\_\_\_

**I understand that:**

1. Treatment and payment will not be conditional on whether I provide Authorization for any requested disclosure by NewYork-Presbyterian Hospital.
2. I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee.
3. This Authorization is voluntary and that I have the right to refuse to sign it.
4. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice; however such revocation would not affect any action taken by NYPH in reliance on this Authorization before receipt of my written revocation.
5. This Authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ (fill in date if less than 1 year) or 1 year after being signed.
6. The information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
7. My medical records may contain genetic testing information including test results.
8. This authorization is also applicable to patients with drug or alcohol related diagnoses, protected by Title 42 of the Code of Federal Regulations. (see reverse side for description)

Signature of patient/personal representative (e.g., legal guardian) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If personal representative, relationship to patient, print name \_\_\_\_\_

**Witness or Notary (This Authorization must be notarized if information is being released to an attorney and/or court.)**

**DEFINITIONS**

1. "Protected Health Information" (PHI): is information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.
2. "Sensitive Protected Health Information" (SPHI): means Protected Health Information that pertains to (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS\*, (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

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**FOR PATIENTS WITH DRUG OR ALCOHOL RELATED DIAGNOSES**

1. I am informed that Title 42 of the Code of Federal Regulations protects the confidentiality of the records of patients with alcohol and drug-related diagnoses.
2. According to Title 42 any person who receives information from the record of such a patient may not show this information to anyone else without my written permission.
3. Any information released with written permission, will be accompanied by a statement, which tells the person who receives the information that he may not show this information to anyone else, unless I give my permission in writing.

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**Medical Correspondence Units**

NewYork-Presbyterian Hospital / Weill Cornell Medical Center  
525 East 68th Street  
Box 126  
Room Payson-04  
New York, NY 10065-4879  
(212) 746-0530

NewYork-Presbyterian Hospital / Columbia Presbyterian Medical Center  
Morgan Stanley Children's Hospital of NewYork-Presbyterian Hospital (CHONY)  
The Allen Pavilion  
622 West 168th Street  
Room PH1-040B  
New York, NY 10032  
(212) 305-3270 or (212) 305-5095

NewYork-Presbyterian Hospital / Westchester Division  
21 Bloomingdale Road  
Hall H, Room 006  
White Plains, NY 10605  
(914) 997-5725



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City State Zip Code

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