ColumbiaDoctors

Clinical Breast Center
161 Fort Washington Avenue New York, NY 10032
T (212) 305-9676 F (212) 342-4164

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize the release of the following protected health information from:

□ **Yale New Haven Health /Greenwich Hospital Fax 203-688-4645**

□ **Breast Imaging CD Fax 203-863-4325**

□ Complete Medical Record □ Progress Notes □ Operative Reports
□ Pathology Reports □ Radiology Reports □ Laboratory Reports
□ Diagnostic Tests □ Imaging Reports □ Radiology Images

□ Other: _____ □ Year(s): _____

Patient has an appointment on _____. Please send records prior to appointment.

Send medical information to:

Name:	Clinical Breast Center, ATTN: Dr. Lisa Wiechmann
Address:	161 Fort Washington Avenue, Room 1004
City, State, Zip:	New York, NY 10032
Phone:	212-305-9676
Fax:	212-342-4164

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Columbia University Medical Center shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information form will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- I understand the purpose of these records is for continuity of care and physician review.
- This Authorization expires on____/___/____(if date not completed / one year after signed)

_____ _____

Patient / Representative Signature **Date**

Retain this form in the patient's medical record and provide a copy to the patient.

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.