Upper East Side Gynecology
www.uesgynecology.com
Carmit Archibald, MD
Valerie Wells, MD

40 E. 84th Street
New York, NY 10028
t 212-472-6500
f 212-988-8737

Authorization for Release of Medical Record/Protected Health Information

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I have read and understand the terms as follows and have had the opportunity to ask questions regarding this authorization. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA),

1. I have the right to revoke this authorization at any time by submitting a written notice to the address above of my decision to revoke consent to the individual, Entity, or Health Care Provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the information disclosed may be re-disclosed if the recipient(s) described in this form is not required by law to protect the privacy of the information, and the information is no longer protected by health information privacy rules.
3. I have been advised that § 18 (2) of the Public Health Law of the State of New York provides that physicians may impose a reasonable charge for copies of a patient's records, not exceeding $0.75 per page. The cost of postage is additional.

_____ _____

Signature Date

Personal Information

Name: _____

Last First Middle

Address Street: _____

City: _____ State: _____ Zip Code: _____

Date of Birth (mm/dd/yyyy): _____

Home phone:_____ Cellular phone: _____

Recipient Information

Name (business/ individual): _____

Address (if different from self) Street: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Fax number: _____

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Medical Record Details

Date range required: From:_____ To: _____

Please indicate if you are [] transferring to another practice (reason) _____

[] consulting another physician [] other_____

Information (specify if appropriate):

[] Doctor Notes

[] Radiology Reports _____

[] Lab Results _____

**PLEASE NOTE PRENATAL AND STI TESTING MAY CONTAIN RESULTS FOR HIV TESTING. IF YOU WOULD LIKE TO RELEASE THESE LABS, PLEASE CHECK APPLICABLE BOXES AND INITIAL NEXT TO EACH CHECKED BOX.

[] Genetic Testing _____

[] STI Testing _____

[] Other _____

[] My entire record _____

Method of Transfer

Please choose one:

[] I will pick up my records at the office (fees apply)

[] I would like my record electronically faxed (at no additional cost)

[] Mail the records via regular mail (fees apply)

[] Fed Ex account number: _____

[] UPS account number: _____