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 healthcare 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 provide 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

Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Home Phone: _____ Cell Phone: _____

Recipient Information

Name (business/individual): _____

Street Address (if different from self): _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____ Email: _____

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

Medical Record Details

Date Range (REQUIRED): From: _____ To: _____

Reason for Release: [ ] Transferring to another practice (reason): _____

[ ] Consulting another physician [ ] Other: _____

Information to Release (specify if appropriate):

[ ] Doctor Notes

[ ] Radiology Reports _____

[ ] Lab Results _____

**PLEASE NOTE PRENATAL AND STI TESITNG 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

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

[ ] I would like my records electronically faxed (at no additional charge)

[ ] I would like my records mailed via USPS (fees apply)

[ ] I would like my records emailed (at no additional charge)

[ ] Fed Ex (please provide account number, fees apply) _____

[ ] UPS (please provide account number, fees apply) _____