Gianna – The National Center for Women's Health and Fertility

Gianna Physician Practice of NY PC

Authorization for Release of Medical Information

Name of Patient:____Date of Birth: ______

Address of Patient:____SS#: ____________

Patient Telephone (Daytime) ______________________________(Evening)________________________

I hereby authorize __________________________

To release the information checked off below to: Gianna Physician Practice of NY PC

Telephone No.: 212-481-1219 Fax No.: 212-481-1423

The following medical information covering the period(s) of hospitalization or treatment from:

____________ TO __________.
(Date) (Date)

☐ In-Patient Hospitalization ☐ Outpatient Treatment ☐ Residential Services

☐ Ambulatory Surgery ☐ Emergency Room Treatment

Information to be disclosed (copied) ☐ **Information to be accessed (inspected/reviewed)** ☐

☐ Complete Health Record(s)

☐ Discharge Summary ☐ Progress Notes ☐ Residential Services

☐ Laboratory Tests ☐ Consultation Reports ☐ Radiology Reports/Films

☐ Psychiatric Assessments / Evaluation ☐ Psychosocial History

☐ Photographs, Videotapes

☐ Full Summary ☐ Explanation ☐ Inspection

☐ Other: (Please Specify)____

I understand that this will include information relating to:

☐ AIDS (Acquired Immunodeficiency Syndrome) or
HIV (Human Immunodeficiency Virus) Infection or tests for HIV Information (Use HIV DOH Authorization form # 2557)

☐ Psychiatric Care

☐ Treatment for Alcohol and/or Drug Abuse

☐ Not Applicable

Purpose for Disclosure:____

Method of Delivery (check one): Pick Up ______ By Mail______

By signing below, I am requesting that Gianna Physician Practice of NY PC provide me with access to health information in the manner described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations. I understand that I will be contacted if any fees for copies, a summary or explanation may be charged for fulfilling this request, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire automatically six months from date on which it is signed (or 60 days with respect to Drug or Alcohol Abuse records). You have a right to refuse to sign this authorization. Your health care, the payment for your health care and your health care benefits will not be affected if you do not sign this form.

______________________________________ ________________ __________

Signature of Patient, If Minor, Signature of Parent of Legal Guardian Relationship Date

______________________________________ __________

Signature of Witness Date

NOTICE TO RECEIPEINT: This information has been disclosed to you from records whose confidentiality is protected by State & Federal Law. State & Federal regulations prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

GENERAL INFORMATION

1. If your request is relevant to continued care by another physician or hospital, we will be glad to copy the information and forward it (fax) directly to another physician or hospital of your choice.
2. This request must be notarized if it is not competed on the hospital premises.