AUTHORIZATION AND REQUEST FOR RELEASE OF INFORMATION

Memorial Sloan Kettering Cancer Center
Health Information Management Department
633 Third Avenue, 11th Floor
New York, NY 10017
Phone: (646) 227-2089
Fax 1: (212) 557-0531 - Fax 2: (646) 227-3545

Patient's Name:

Date of Birth:

MRN:

Please indicate below the nature of request for medical records:			
☐Physician/Medical Facility	☐Attorney	☐Self/Family Member	☐Insurance/Disability

I hereby authorize and give consent to Memorial Hospital and respective agents and employees, to furnish the medical record specified below to the following person, agency or organization whose name and address I provide:

Name:

Address:

City, State, Zip Code:

Phone:

Fax:

Please check the following information you would like released:

☐Labs Reports	☐Pathology Reports	☐Radiology Reports
☐Operative Reports	☐Discharge Summary	☐Consultation Reports
☐HIV Related Information*	☐Genetic Information	☐Medical Abstract
☐Other		

*****HIV-related information is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV*

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The Words "at the request of the individual" is a sufficient description of the purpose when a patient initiates the authorization and chooses not to provide any further explanation of the purpose.

At the request of the individual

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.

One year from the date signed

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipients(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.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 1-800-523-2437 or (212)480-2493, or the New York City Commission of Human Rights at (212) 306-7450 or (212) 306-7500. These Agencies are responsible for protecting your rights.

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.

You have a right to see and copy the information described on this authorization form in accordance with hospital policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to the Privacy Office at the hospital.

SIGNATURE

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Patient or Personal Representative	Date
Print name of Patient or Personal Representative	Description of Personal Representative's Authority