

RELEASE OF MEDICAL RECORDS

I, _____, authorize: _____ to disclose the following medical information to:

_____, MD
Weill Cornell Medical Associates
201 East 80th Street
New York, NY 10075
646-962-7300 (voice)
646-962-0409 (fax)

I specifically authorize the release of the following:

Entire Record **Only those items listed below:**

- History and Physical
- Laboratory Tests
- Human Immunodeficiency Virus (HIV) Antibody test results and treatment information.
- Electrocardiogram (EKG)
- Registration Record/Information
- Radiology (X-ray) Reports
- Other (specify) _____

I expressly and voluntarily authorize disclosure of the above medical record information. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release is effective for 90 days from the date signed, unless otherwise specified as follows: _____

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained for me, or unless such disclosure is specifically required or permitted by law.

Signature

Date

Patient's SSN

Patient's DOB

Print Name (State Relationship if other than Patient)