



## Request a Copy of Medical Records

(Required by HIPAA, the Health Insurance Portability and Accountability Act)

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

### My Authorization

I authorize you to copy and disclose the following health care information (check all that apply)

All my health information maintained by Central Park Hematology & Oncology

My health information relating to the following treatment or condition \_\_\_\_\_

My health information for the date(s) \_\_\_\_\_

Other \_\_\_\_\_

You may release this health information to

Myself

Other

Name (or title) and organization \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

This authorization ends

On (date) \_\_\_\_\_

When the following event occurs \_\_\_\_\_

### My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I understand that under New York State Law I will be charged \$0.75 per page regardless of format (printed, faxed, emailed or digital).

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (if signed on behalf of the patient)

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative, etc.)