

Women's Medical Care of Hudson Valley, P.C.

9 Hudson Valley Professional Plaza, Newburgh, New York 12550

Phone 561-0990 / Fax 562-1439

Web Site www.womensmedicalcare.com

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 7-10 business days for copying. There is a fee of 75 cents per page for copies of medical records.

The medical records cannot be released until this form is completed and signed by the patient or legal guardian.

You must complete this form thoroughly.

PLEASE PRINT

Step I: Patient Name _____ Date of Birth _____

Address _____

Street

City

State

Zip Code

Step II: I hereby authorize Women's Medical Care of Hudson Valley, P.C. _____ to release or to _____ obtain my health information .

Name of Physician/Medical Facility _____

Address _____

Street

City

State

Zip Code

Phone #

Fax #

Step III: Information to be released: _____

Date (s)/Condition (s)

_____ Transferring out of the practice Reason: _____

(This section must be completed before records will be released)

_____ 2nd Opinion/will be continuing care with the practice

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for 90 days for the release of information as indicated above. **Only records from this facility can legally be released.** Any records from other physicians must be obtained from them.

Patient Signature & Date

Parent/Guardian Signature & Date

Witness Signature & Date

Physician Signature & Date

Date Copied _____

#Pages Copied _____

Copied By _____

Signature at Pick Up: _____

Mailed: _____

Faxed: _____