CABRINI
MEDICAL CENTER

OBTAINING A COPY OF YOUR MEDICAL RECORDS:

THESE INSTRUCTIONS ARE AVAILABLE IN SPANISH – SEE WWW.CABRININY.ORG

1. Print the attached MEDICAL RECORDS RELEASE FORM. For medical records to be released, the form must be completed, initialed and signed.

2. If records are being mailed directly to a physician, write the physician's name and address in the designated area.

3. Patients must include a copy of a drivers' license or other photo ID.

4. Mail these items to:

Cabrini Medical Center
227 East 19th Street
New York, New York 10003
Attn.: Medical Records

NOTE: There is a $0.75 cent fee per page. If you want your records to go directly to a physician there is no fee.

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Med. Record # _____
Last Name *First Name*

Address: _____
Street *Apt. #*

_____
City *State* *Zip*

Telephone # _____ SS# _____ Date of Birth: _____

I hereby authorize CABRINI MEDICAL CENTER to disclose copies of my health information to:

Name: _____

Address: _____

_____

Phone #: _____ FAX #: _____

Please release the specific information described below:

_____

_____

The purpose for which the information will be used or disclosed: _____

IF THE REQUESTED RECORD CONTAINS INFORMATION PERTAINING TO *PSYCHIATRIC, DRUG OR ALCOHOL TREATMENT* OR CONTAINS *HIV RELATED INFORMATION*, YOU MUST SPECIFICALLY CONSENT TO THE RELEASE OF SUCH INFORMATION BY INITIALING ONE OR BOTH OF THE FOLLOWING:

_____ initial I understand that if my records contain information pertaining to psychiatric, drug or alcohol treatment, such information will be released pursuant to this consent form

_____ initial I understand that if my records contain confidential HIV information, such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV

This authorization is valid for 1 year from the date of the patient's or patient's representative's signature unless otherwise specified: _____
The date or event that will trigger the expiration

The hospital will be compensated for the cost of copying, mailing or other supplies we use to fulfill your request in accordance with NYS law.

I have read this form and all of my questions about this form 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 Representative's Authority

Mail Completed Form with a Copy of Photo ID to:
CABRINI MEDICAL CENTER, 227 East 19th Street, New York, N.Y. 10003 Attn.: Medical Records