Print Form

Authorization for Records Release/Request

FEE: .75 cents per page

Please Send or Fax Request:
Yaffe, Ruden & Associates, LLP
Attn: Yvette Bailey, Medical Records Dept.
201 East 65th Street
New York, New York 10065
Phone: 212.8794700 X #6292
Fax: 212.750.9654

HIPPA♦Authorization

For Disclosure of Health Information

Section A: Patient Identification (Required)

Patient Name (please include any maiden name or alias):	**Sex:**	**Date of Birth:**
Address:		
Email:		
Home Phone:	**Cell Phone:**	
Home Fax:	**Work Phone**:	
If requested by Personal/Legal Representative (Name & Relationship):		

Section B: Request for Copying of Your Health Information

You have a right to obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. To submit a request, please fill in the following information:

Indicate preference:

☐ I will pick-up the copies requested

☐ Please mail the copies I requested to the address above

☐ Please release a copy of my medical records to the individual or organization listed on the other side of this form

☐ I hereby authorize the release of all medical records to:

Yaffe, Ruden & Associates, LLP
201 East 65th Street, New York, New York 10065

- New York State law allows physicians and institutions to charge no more than .75 cents per page with a turnaround time of 30 days after payment is received.
- You agree to pay any fees (if applicable) associated with copying, and mailing the above records.
- **Please Note: Records must be paid in advance. We accept cash, check, money order, and credit cards. The cost of copying ____ Pages of the above patient's medical records at $.75 per page $___, plus $_____ for shipping and handling totaling $_____.**

*** Copies will not be printed prior to receiving payment. ***

Cont. →

Section C: Health Information to be Accessed or Disclosed (to be requested by all requestors)
Access and/or disclosure shall be limited to the following elements of my health information:

☐ Medical Notes ☐ Consultation Report(s) ☐ Immunization Record ☐ History & Physical
☐ Laboratory Test(s) ☐ X-ray Films ☐ Progress Notes ☐ Operative Report(s)
☐ Pathology Report(s) ☐ Radiology (X-rays) Report(s)
☐ Other (specify):_____

☐ **All of the above from Date**: _____ to _____

Section D: Authorization for Disclosure of Health Information *(complete only if this closure is to someone other than or your personal/legal representative)*

I herby authorize Yaffe, Ruden & Associates to release a copy of my medical records to the person/organization specified below:

☐ Will Pick-Up or ☐ Mail To:

Release my medical information to: _____

Address:_____

City:_____ State: _____ Zip Code:_____

Section E:

Patient Signature: _____ Date: _____

If signed by other than the patient, indicate relationship: _____

Payment Information:

☐ **Check (Please make your check payable to Yaffe, Ruden & Associates, LLP)**

○ **Visa** ○ **Master Card** ○ **Discover** ○ **AMEX** ☐ **Check**

Credit Card#:

Expiration:

_____ / _____

Signature: _____ Date: _____

(Rev 2013)

Reset Form