Spring Ob/Gyn, PC

135 Spring Street, 2nd Fl • NYC 10012
Tel. 212.219.1187 • Fax 212.219.1538

OUTGOING RECORDS RELEASE

This form must be filled out in its entirety before we can comply with records requests.

New York State law requires all patients requesting the release of their medical records to give permission in writing. Permission to release HIV related records to any person, company or institution must also be specifically requested in writing.

Name: ______________________________

Date of Birth:___________________________

Are you transferring your care out of our office?

□ Yes □ No

By completing this from, I authorize Spring Ob/Gyn to release a copy of my medical records to:

____

____

Please provide records via: (choose one)

□ Regular Mail: ____

□ Password protected PDF E-mail: __________________________________

□ Fax: _______________________________ □ Picked up in person at the office

Reason for request:

□ Insurance Change □ Moving □ Transferring Care □ Other:______________________

If you only require specific reports or results, please specify which ones below:

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NOTICE

Spring Ob/Gyn PC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorizations is for 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in health plan, 3) to determine an entity's obligation to pay claim, 4) to create PHI to provide to a third party

I may revoke this authorization at any time, provided that I do so in writing and submit it to:
Spring Ob/Gyn
135 Spring Street, 2nd Floor,
New York, NY 10012

Patient/Representative Signature: _____________________________

Relationship to Patient: ______________________________

Date: ____________________________

All medical records requests will take 3-5 business days from the date the signed request is received.

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