HIPPA Authorization For Disclosure of Health Information

Please send or fax request to:

New York Headache Center
30 East 76 Street
New York, NY 10021
Phone 212-794-3550
Fax: 212-794-0591

FEE: 75 cents per page

Patient Identification (Required)
Patient Name (include maiden name or alias):_____

Date of Birth: _____

Address: _____

Email: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Home Fax: _____

If requested by Personal/Legal Representative (Name & Relationship):
_____

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:

New York Headache Center
30 East 76 Street
New York, NY 10021

• 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 printing/copying, and mailing the above records.
• Please Note: The fee must be paid in advance. We accept cash, check, 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. *

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) __History & Physical
__ Laboratory Test(s) __X-ray Films & reports __Progress Notes
Other(specify):_____
All of the above from Date: _____ to _____

Authorization for Disclosure of Health Information (complete only if this closure is to someone other than or your personal/legal representative)
I herby authorize the New York Headache Center to release a copy of my medical records to the person/organization specified below:

___Will Pick-Up ___Mail To:

Release my medical information to:

_____

Address:_____

City:_____State: _____ Zip Code:_____

Patient Signature: _____ Date: _____

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

Payment Information:
Check payable to: **New York Headache Center**

Visa MasterCard Amex Credit Card#: _____

Expiration: _____ / _____

Signature: _____ Date: _____