NewYork-Presbyterian
The University Hospital of Columbia and Cornell

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND ACKNOWLEDGEMENT OF RESPONSIBILITY

No physician or institution may give confidential information without the consent of the patient. If the patient is a minor, the consent form must be signed by the parent or legal guardian and should be witnessed.

This process takes approximately **5-7 business days**.

It is preferable to have the slides and reports sent directly to the physician that will be performing the consultation. However, the patient and/or their representative may pick up the material directly. **Proper photo ID**, proof of payment and this completed form must be provided when picking up slides. If any changes are requested once the paperwork has been submitted, please contact the office with a written documentation of the changes.

Patient's Last Name: _____ First Name: _____

Address: _____ City, State, Zip: _____

DOB: _____ PH: _____ Email: _____

Date(s) Procedure was performed: _____

I am requesting NYPH to Express Delivery/FedEx this material

OR

I or the person designated _____ will be picking up this material. You or your
(Print Name and Phone #)

designee must provide proper photo identification for release.

Materials are being sent to:

Dr.:_____ at _____
(First and Last Name of Physician) (Name of Institution)

_____ _____
(Address of Institution) (Phone Number)

I hereby acknowledge receipt of the items, *which I am removing or am having sent* (see above) from the premises of NewYork-Presbyterian Hospital. I hereby further acknowledge that I have been advised that either all of the material or a portion of the material needed to render a diagnosis is contained within the above-listed information. I further understand this request or additional materials may exhaust the tumor for future studies. I further understand that loss of or damage to the material after it has been removed from the premises of NewYork-Presbyterian Hospital may mean that diagnostic material or information similar to that in the lost or damaged items can never be obtained again. I agree to return to New York-Presbyterian Hospital all original materials as soon as possible. If the original information is not returned, I release NewYork-Presbyterian Hospital from all claims, liabilities, obligations, loses or damages that may arise from the unavailability of the material.

Requester: _____ _____ _____
Print Patient Name or Health Care Proxy Name Signature Date

Note: Please provide proper documentation of Health Care Proxy and identification.

_____ _____ _____
Relationship to Patient (If signed by other than the patient) Signature Date

For office use only:

*NYPH Case No:*_____ _____ _____

Payment Method: __ Check __ Cash __ Money Order __ Credit Card – Receipt No: _____ Other _____

Request Recv'd on _____Warehouse requested on _____ Sent out/Picked up: _____ Verified by: _____

NYPH Staff only, please note date, time and initials