

Instructions for requesting Medical Records

- Write clearly in a black or blue ink.
- The patients name should be the name of the patient at the time of treatment.
- Specify the “from” and “to” dates that you would like to request. If you are requesting information from one date of service, repeat the same date in the “to” and “from” fields.
- Be as specific as you can. Check only the boxes that apply to your request.
- Specify the reason for the request and if the patient will be transferring from our care.
- No HIV results will be released unless the specific HIV authorization form is completed.
- There is a fee of \$0.75 per page. Postage is additional.
- Failure to complete the credit card authorization may delay processing.
- Federal and State guidelines limit Lexington OB/GYN to release “Minimum Necessary” information.
- Only a signed and completed authorization will be considered.
- If you would like to receive your records by FedEx or UPS, you must provide the office with your personal FedEx or UPS account number.
- Allow 10 business days to process your request.

***** Notice *****

The office preference is to always release the medical records directly to the patient. This way the patient always has a copy of her records and can provide a copy to other healthcare providers at any time.

If the office releases the records to a recipient other than the patient, and that recipient denies receiving the records, then an additional fee will be incurred by the patient for recopying the records.

Mail your completed forms to:

Lexington OB/GYN
145 East 32nd Street
11th Floor,
New York, NY 10016
Attention: Medical Records Department

Fax your completed forms to: (212) 686-1920

AUTHORIZATION TO USE OR DISCLOSE PROTECTIVE HEALTH INFORMATION

Patient Name: _____
(Last) (First) (Middle) (Maiden Name)
Current Address: _____
(Street) (Apartment #)

(City) (State) (Zip)
Telephone #: (_____) _____ (_____) _____
(Home) (Work)
Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____

Recipient: Name and Address of Company, doctor or individual to whom the information is to be disclosed: Same as above
Name of Organization/Individual: _____
Address: _____
(Street) (Apartment)

(City) (State) (Zip)
Phone: (_____) _____ Cell: (_____) _____

How would you like us to get you the records?
 I will pick up the records from the office Mail the records via regular mail
 FedEx account # _____ UPS account #: _____

Information to be disclosed:
(Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc,)
Date range requested: From: _____ To: _____
 Office notes Pap smears Biopsies Colposcopy Office procedures Lab tests Surgeries Radiological reports
 Others (specify) _____
Under New York State Law, the following Protective Health Information requires additional authorization. Please check the appropriate box(s) if you are requesting the disclosure of any of the items.
 Genetic Results Substance/Alcohol Abuse Records Mental Health Records Sexual transmitted diseases (STD)

Use or disclosure of Protective Healthcare Information (check all that apply):
 I am **transferring** from the practice because of Relocation Insurance change Hospital Other (specify on line below) _____
 I am **not transferring** from the practice but need my records for Another physician Other _____

Term: This authorization will remain in effect from the date on this authorization until Lexington OB/GYN fulfills the request.

AUTHORIZATION:
- I understand that once Lexington OB/GYN discloses my health information to the recipient in accordance with the terms and conditions of this authorization, Lexington OB/GYN cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Lexington OB/GYN's treatment of me; except, however, if my treatment at Lexington OB/GYN is for the sole purpose of creating PHI for disclosure to the recipient identified in this authorization, in which case Lexington OB/GYN may refuse to treat me if I do not sign this authorization.
- I understand that this authorization will remain in effect until the term of the authorization expires or I provide written notice of revocation to the Privacy Officer at the address listed below. The revocation will be effective immediately upon Lexington OB/GYN's receipt of my written notice, except that the revocation will not have any effect on any action taken by Lexington OB/GYN in reliance on this authorization before it receives my written notice of revocation.
- I have been advised that §18(2) of the Public Health Law of the State of New York provides that physicians may impose a reasonable charge for copies of a patient's records, not exceeding \$0.75 per page. The cost of postage is additional.
- I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Lexington OB/GYN to use or disclose my health information in the manner described above.
Signature of Patient or Personal Representative: _____ Date: _____
Name and Authority of the Personal Representative: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV* RELATED INFORMATION

Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights as (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

Name of person whose HIV related information Will be released:	_____
Name and address of person signing this form (if other than above):	_____ _____
Relationship to person whose HIV information Will be released:	_____
Name and address of person who will be given HIV related information:	_____ _____ _____
Reason for release of HIV related information:	_____
Time during which release is authorized:	From: _____ To: _____

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

Signature: _____ Date: _____

* Human Immunodeficiency Virus that causes AIDS.

Lexington • Ob Gyn

CREDIT CARD AUTHORIZATION FORM

§18(2) of the Public Health Law of the State of New York provides that physicians may impose a reasonable charge for copies of a patient's records, not exceeding \$0.75 per page. The actual cost of postage is additional.

To expedite your request, please complete the following credit card information. Also, it is our office policy to maintain a credit card on file. Should the account fall into arrears greater than 30 days or if there is a balance on the account after the insurance has met its responsibility, I authorize that the unpaid balance be charged to my major credit card, as listed.

Patient Name: _____

Credit Card Information:

- Visa
 MasterCard

Account #: |__|__|__|__|■|__|__|__|__|■|__|__|__|__|■|__|__|__|__|

Expiration: |__|__|■|__|__|__|__|

V-code: |__|__|__|__|__|__| (3, 4 or 7 digit security code)
MM Y Y Y Y

Credit Card Billing Address:

Street: _____

City: _____ State: _____ Zip: _____

Card Member's Name: _____

Card Member's signature: _____

Today's Date: _____

If we can be of any further assistance in this matter, please contact the Medical Records Department at (212) 686-8686.