Medical Records Release Form

(Release from Scarsdale Medical Group)

To request release of medical/health information, please complete and sign this form and return it to:

Scarsdale Medical Group, LLP
Health Information Department,
600 Mamaroneck Avenue, Suite 200, Harrison NY 10528
Fax: 914-219-1933
Email: healthinformation@scarsdalemedical.com

If you need help completing this form, Please contact our Health Information Department at (914) 723-8100, Ext. 158

Patient Information:

Last Name _____First Name _____ Date of Birth____/____/_____
Street Address_____City_____
State _____Zip_____ Telephone_____

Information Requested: (please be specific and include dates of service)

_____

_____

_____

Restrictions and Exclusions: □ ***Psychiatric*** □ ***HIV/Aids Testing*** □ ***STD Testing***

Medical Records are to be released to:

Doctor/Recipient _____Practice Name_____
Street Address_____
City_____ State_____ Zip_____
Telephone Number_____ Fax Number_____

Reason for requested Information disclosure:

□ Transfer of health coverage □ Personal Use □ Form Completion □ Referral □ Change of healthcare provider

****If your request is for purpose of personal use, other than continuity of care, please be aware that a reasonable, cost-based fee for copies of medical records may apply. Once the request is processed, the requestor will be sent an invoice with a list of ways to submit payment. *****
** CHECKS MUST BE PAYABLE TO: "Ciox Health" ****

I hereby authorize Scarsdale Medical Group to release any medical information as requested above. This may include information about drug and/or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can, however, revoke this authorization at any time, except to the extent that Scarsdale Medical Group has acted upon it. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer be protected by federal law.

I understand that the Scarsdale Medical Group will continue to provide care, even if I do not authorize this release.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (if minor) Date

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.

This release is intended to comply with the Health Information Portability and Accountability Act (HIPAA).