OPEN DOOR
FAMILY MEDICAL CENTERS

5 Grace Church Street, Port Chester, NY 10573
Tel: 914-937-8899 Fax: 914-937-7932

Medical Record Release Authorization

Other Locations:
☐ **Open Door Ossining**
Tel: 914-941-1263 Fax: 914-941-8626
☐ **Open Door Sleepy Hollow**
Tel: 914-631-4141 Fax: 914-631-1867
☐ **Open Door Mount Kisco**
Tel: 914-666-3272 Fax: 914-666-3287
☐ **Open Door Brewster**
Tel: 845-279-6999 Fax: 845-279-0908

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____FAX#_____

C) For the purpose of:

_____ Litigation
_____ Insurance
_____ Self/Personal Copy
_____ Transfer or Continuity of Care
_____ Disability
_____Work Comp
_____Other

Date Range_____to_____

☐ Physician Office Notes ☐ Cardiology/EKG Reports ☐ Operative/Procedure Reports
☐ Immunizations ☐ Lab/Path Reports ☐ Radiology/XRay/MRI Reports
☐ Other _____ ☐ Minimum Necessary

Include (Indicate by Initialing below): If not initialed information will not be released.
By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

____ Alcohol/Drug Treatment ___ HIV/AIDS Related Information
____ Mental Health Treatment ___ Genetic Testing

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

_____ _____**Subject to Fees
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

*PLEASE READ

Fee Information: **Open Door Family Medical Centers** contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical record stated fee structure as set forth in the NYS Article 18 Public Health Law. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.