

OBGYN WESTSIDE

620 Columbus Avenue
New York, NY 10024
Ph: 212-580-3866; Fax: 212-580-3867

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ DOB: _____

Previous Name: _____ Social Security #: _____

() I authorize OBGYN Westside to fax/scan (preferred method) a copy of my medical records to:

() I authorize OBGYN Westside to request my medical records from:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax: _____

This request and authorization applies to:

- Healthcare information relating to following treatment, condition, or dates:

- All healthcare information

- Other: _____

Please login into your Mt. Sinai My Chart and check for results before requesting the results.

We require 10-14 business days to process your request. There is charge of (\$0.75) per page. We charge expediting fees for urgent requests: \$35 - 'within 24 hours' and \$25 - 1-2 business days.

FYI: We store all paper records (more than 3 years old) in an offsite storage facility.

Signature: _____ Date: _____