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**. The administrative fee for this service is **$30.00** and ***the materials will be released upon completion of processing and receipt of payment***. Payment may be made by credit card, check, money order or cash. Payment by check or money order can be mailed to the address above and made out to NYP Pathology Department. For payment by credit card please provide email address below and a payment link will be sent.

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: _____ Phone: _____ Date(s) Procedure was performed on: _____

Provide Email address for credit card payment: _____

☐ **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: ☐ **I acknowledge these are original non reproducible materials being released.**

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

_____ _____
(Address of Institution) (Phone Number)

I hereby acknowledge receipt of the non-reproducible 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