



New York House Call Physicians™

YOUR DOCTOR IN THE FAMILY

Authorization of Medical Record Release

I, _____, hereby authorize release of my medical records to New York House Call Physicians.

New York House Call Physicians requests only the following pertinent and succinct medical record information be forwarded from other medical and health care providers:

- Problem Lists
- Vaccination History
- Past and Current Medical History
- Past Surgical History
- Current Medications and pertinent past medications
- Social History
- Allergic History
- Recent Physical Exam
- Pertinent and Recent Laboratory and Radiology Tests
- Additional Pertinent Information at the health care provider's discretion

Notice of Privacy Practices:

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), New York House Call Physicians™ will keep all of your health information confidential.

Note that for the purposes of medical treatment (e.g. mediating prescriptions, discussing your case with a consulting physician), payment (e.g. insurance paperwork which shows your diagnosis and corresponding diagnostic codes), health care operations (e.g. self-auditing our medical records, quality improvement), and medico-legal considerations (e.g. medical examiners, law enforcement officials, public health authorities), your health information may be obtained or disclosed by telephone, email, mail, or fax.

Patient Name: _____

Patient Address: _____

Patient Telephone &/or Cell Phone: _____

Patient Date of Birth: _____

Patient Email _____

My signature below indicates that I authorize medical record release to New York House Call Physicians.

Patient or Guardian Signature: _____

Today's Date & Time: _____