Village Obstetrics™
MUSSALLI · WORTH

1225 Park Avenue
New York, NY 10128

phone 212-741-2229
fax 212-741-2228
email info@villageob.com

Records Request Form

Instructions:

1. Please complete the form and sign it
2. Email the completed form to: info@villageob.com
   Alternatively, you may fax it to: **212-741-2228**
3. For any questions, contact us at **212-741-2229**

Office Address:

Village Obstetrics
1225 Park Avenue
New York, NY 10128

PATIENT INFORMATION:

Patient's Full Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Email Address: _____

MEDICAL RECORDS REQUESTED:

I hereby authorize Village Obstetrics ("Releasor") to use or disclose the following (check one):

☐ **ALL Medical Records**
I request the release of my complete health record, which may include protected health information (PHI) and electronic protected health information (ePHI) under HIPAA.

☐ **Specific Medical Records:** _____

DELIVERY OPTIONS:

Please choose how you would like to receive your records:

☐ **In-Person Pickup** ☐ **Email Delivery** *(to myself or doctor)* ***By signing below, I consent to the delivery of my records via unencrypted email.***

☐ **Fax to My Doctor** ☐ **By FedEx** *($50 charge; please call our office to provide your credit card information over the phone)*

RECIPIENT INFORMATION:

Name: _____ Contact: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Email Address: _____ Fax Number: _____

Purpose of Release: _____ This authorization expires on: _____

ACKNOWLEDGMENT:

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization. I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based on my original permission. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Signature: _____ Date: _____

Printed Name: _____