Scarsdale Medical Group | White Plains Hospital

Medical Records Release Form

(Release from Scarsdale Medical Group)

To request release of medical/health information, please complete, sign this form and return it to:

Scarsdale Medical Group: Health Information Department
600 Mamaroneck Avenue, Suite 200, Harrison NY 10528
Fax: 914-219-1933
Email: healthinformation@scarsdalemedical.com

For assistance completing this form, contact our Health Information Department: (914) 723-8100 ext. 171

To check the status of a request, contact CIOX Health: (914) 723-8100 ext. 158

Patient Information:

Last Name ________________________ First Name ________________________ Date of Birth____/____/________
Street Address____City______________________________
State ____________________Zip________________ Telephone____

Information Requested: (please be specific and include dates of service)

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Restrictions and Exclusions: ☐ ***Psychiatric*** ☐ ***HIV/Aids Testing*** ☐ ***STD Testing***

Medical Records are to be released to:

Doctor/Recipient ________________________________ Practice Name_____________________________________
Street Address____
City_____________________________________ State___________________ Zip_________________________
Telephone Number_________________________________ Fax Number______________________________________
☐ **Send my records via secure email (**Email address: _______________________________________)

Reason for requested Information disclosure:

☐ Transfer of health coverage ☐ Personal Use ☐ Form Completion ☐ Referral ☐ Change of healthcare provider

****If your request is for purpose of personal use, other than continuity of care, please be aware that a reasonable, cost-based fee for copies of medical records may apply. Once the request is processed, the requestor will be sent an invoice with a list of ways to submit payment. ****

***** CHECKS MUST BE PAYABLE TO: "Ciox Health" *****

I hereby authorize Scarsdale Medical Group to release any medical information as requested above. This may include information about drug and/or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can, however, revoke this authorization at any time, except to the extent that Scarsdale Medical Group has acted upon it. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer be protected by federal law.

I understand that the Scarsdale Medical Group will continue to provide care, even if I do not authorize this release.

____ ______________________
Signature of Patient Date

____ ______________________
Signature of Parent/Guardian (if minor) Date

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.

This release is intended to comply with the Health Information Portability and Accountability Act (HIPAA).