MADISON
WOMEN'S HEALTH & FERTILITY, PC

Cristina Matera, MD, FACOG | Maureen O'Brien Moomjy, MD, FACOG | Jessica Rosenberg Brown, MD, FACOG

REQUEST FOR ACCESS TO HEALTH INFORMATION

I hereby authorize the release of:

__ Medical records for the following dates. _____

__ Specific part of the medical record. _____(__/__/__)

__ Billing records for the following date(s). _____

__ Other. Please specify. _____

that document(s) the care that I received by the gynecology practice of Drs. Matera, Dr.Moomjy and/or Dr. Brown. Please indicate the reason for the release of the medical records:

_____

_____

Include HIV testing, if done ___Yes ___No ___N/A

Include HIV related information. ___Yes ___No

(Please be aware that this may comprise a significant component of your records given the nature of gynecologic care, i.e. sexual activity is a potential risk factor for HIV exposure.)

Other restrictions _____

I hereby request to inspect my health information. __ Yes __ No

I understand that I must schedule an appointment to inspect the records. I also understand that I will not be allowed to modify the records or remove them from the premises of the medical practice.

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reasons(s) listed on the form. You do not have to sign the form, and you can change your mind at any time. If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

We charge fees for copy and postage, as permitted by applicable state and federal laws. You will be informed of the total due before your copies are provided to you.

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Please send via USPS/FedEx/Pick-up (please circle) my health information to:

_____
Name of Facility

_____
Name

_____
Address

_____
Address

_____
Phone

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time. I release you, your physician and employees from liability for allowing this authorization and request.

_____
Patient Name

_____
Witness Name

_____
Patient Address

_____
Witness Address

_____
Patient Signature

_____
Witness Signature

_____
Date of Birth

_____
Date

_____
Date

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