Women's Cancer Care Associates, LLC

Authorization for Release of Medical Record Information

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

Medical Records
Women's Cancer Care Associates
319 S Manning Blvd
Suite 301
Albany NY 12208

You may also submit this form by Fax to: (518) 694-8872

Please contact our office (518) 458-1390 with any questions.

Patient Information

Patient Last Name_____ First Name_____ MI
Street Address_____ Apt#_____
City_____ State_____ Zip_____
Date of Birth_____ Phone#: _____

Women's Cancer Care Associates has my permission to release the following information contained in the medical records of the above-named patient

Information Requested

☐ Entire Record, including (check all that apply)
☐ Genetics ☐ HIV Status ☐ Psychological Records

☐ Records related to a specific condition only (list) _____

Inclusive Dates of Records Requested: _____

Purpose of Release ☐ Transferring care from WCCA to another practice ☐ Coordination of care ☐ Second Opinion

☐ Personal copy

Women's Cancer Care Associates will provide the information requested above to the following party:

Name_____
Attention_____
Street Address_____ Apt#_____
City_____ State_____ Zip _____

Telephone #_____ Fax# _____

I hereby authorize Women's Cancer Care Associates (WCCA) to release any medical information as requested above. I am aware that WCCA cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at WCCA may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that WCCA has relied upon it. For example, if I cancel it after WCCA has sent the requested records, WCCA is not responsible for retrieving those records.

_____ _____
Signature of Patient (if 18 years or older) Date

_____ _____ _____
Signature of Parent/Guardian/Other Authorized Party Relationship to Patient Date