

Request for Medical Records/Access to Health Information – Please read carefully.
The HIPAA form follows these instructions.

If you wish to have CWRC release part or all of your medical records to you, a personal representative, or another physician or medical facility, please complete the attached *Authorization for Release of Health Information Pursuant to HIPAA* form. Per New York State law, Medical Records Requests are completed within ten (10) days. ***Please note: Each partner must complete a separate request form.***

Please send the completed *Authorization for Release of Health Information Pursuant to HIPAA* form(s) via email, mail, fax, or in person to:

Center for Women’s Reproductive Care at Columbia University
Medical Records Department
1790 Broadway, 4th Floor (between W. 57th and 58th Streets)
New York, NY 10019
Fax 646.756.6293
Email: Ms. Tonya Worrell, Medical Records Assistant, tw2496@columbia.edu

HIV- and Genetics-Related Health Information

If you wish to have HIV- and/or genetics-related health information released, please indicate this on the release form with your initials. ***Please note: HIV/AIDS, substance abuse, and mental health information cannot be sent via fax, per NY State law.***

Releasing Your Records

We can provide you with a copy of your records at a cost of \$0.75 per page. You will not be charged for records sent directly to your designated physician/medical facility by mail or fax.

Medical Records can be collected in person, mailed, or faxed to you, your personal representative, or your designated physician/medical facility. ***We do not email medical records.*** All requests for records to be mailed or faxed must be clearly indicated on the release form. ***Please print all names, addresses, and fax numbers completely and clearly to avoid processing delays.***

Records are available for pick-up Monday through Friday from 9.00 am to 3.30 pm at CWRC (address above). If someone is collecting your records on your behalf, you must provide a signed letter of authorization. This letter must contain the name of the person you are authorizing to collect your records, your name, and your date of birth.

If you are a patient at our Scarsdale location please follow the instructions above and use the following address:

Center for Women’s Reproductive Care at Columbia University
Medical Records Department
696 White Plains Road
(Vernon Hills Shopping Center)
Scarsdale, NY 10583
Phone 914.723.7000
Fax 914.723.7002