AZ Medical Services
Zergabachew Asfaw, M.D., FACP, CMD
2426 Eastchester Rd, Suite 101, Bronx, NY 10469 Phone (718) 708-4726 Fax (347) 336-6232

Release of Medical Records

Authorization to send records to AZ Medical Services

Use this form to ask your previous doctor, hospital or other provider to send your medical records to AZ Medical Services. Complete every section, sign it, and either give it to the office or send it directly to your previous provider.

1. PATIENT

Last name | First name | Middle initial

Other names used (e.g. maiden name) | Date of birth

Address | Phone

2. SEND RECORDS FROM (PREVIOUS DOCTOR OR FACILITY)

Doctor or facility name | Phone

Address | Fax

3. SEND RECORDS TO

AZ Medical Services, attention Zergabachew Asfaw, M.D., FACP, CMD
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Phone (718) 708-4726 Fax (347) 336-6232

4. INFORMATION TO BE RELEASED

- ☐ Complete medical record
- ☐ Problem and medicine lists
- ☐ Hospital discharge summaries
- ☐ EKG / heart tests
- ☐ Last 2 years only
- ☐ Lab results
- ☐ Specialist consultations
- ☐ Office / visit notes
- ☐ X-ray / imaging reports
- ☐ Immunization record

Other, or dates of service (from / to)

Sensitive information. The records listed above will **not** include the following unless you initial here. Under New York law, HIV-related information needs your specific written consent, and federal law (42 CFR Part 2) protects records from alcohol or drug treatment programs.

_____ I authorize release of: HIV / AIDS-related information

_____ I authorize release of: Mental health / psychiatric information

_____ I authorize release of: Alcohol or drug treatment records

_____ I authorize release of: Genetic testing results

5. PURPOSE

- ☐ Continuing medical care
- ☐ At the request of the patient
- ☐ Other (write below)

Other purpose

Confidential patient information. Please bring this form to your visit or fax it to (347) 336-6232. Please do not email it.

6. EXPIRATION

This authorization ends: ☐ One year from the date signed ☐ On this date or event:

Date or event (if different)

7. YOUR RIGHTS

- I understand that signing this form is voluntary. My treatment, payment, enrollment or eligibility for benefits will not depend on whether I sign it.
- I may revoke (cancel) this authorization at any time by writing to the provider named in Section 2. Revoking it does not affect anything already released before the provider received my request.
- Information released under this authorization may be re-disclosed by the person receiving it and may no longer be protected by federal privacy rules. New York law limits re-disclosure of HIV-related information, and federal law limits re-disclosure of alcohol and drug treatment records.
- I have the right to receive a copy of this form. In New York, a provider may charge a reasonable fee for copies, up to 75 cents a page, but may not refuse to send records needed for my ongoing care only because I cannot pay.

8. SIGNATURE

Signature of patient or legal representative

Date

Printed name

If signed by a representative: relationship / legal authority

A representative must attach proof of authority, such as a health care proxy, power of attorney, or guardianship papers.

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