

# DIGESTIVE DISEASE AND NUTRITION CENTER OF WESTCHESTER, LLP.

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## Authorization to Release/Obtain Medical Records from Hartsdale Medical Group

**Instructions:**

(1) Complete this entire form to release/obtain medical record and fax to (914) 683-1026

I hereby authorize the disclosure of information from the health records of:

Patient's First Name	Patient's Last Name	Former or Maiden Name
Phone Number (with area code)	Social Security Number	Date of Birth
Current Primary Care Doctor		

**Health Information to disclose:**

- |   |   |
|---|---|
| <input type="checkbox"/> all information      | <input type="checkbox"/> labs & imaging studies                 |
| <input type="checkbox"/> treatment summary    | <input type="checkbox"/> dates of treatment attendance          |
| <input type="checkbox"/> diagnoses            | <input type="checkbox"/> progress note entries - date(s): _____ |
| <input type="checkbox"/> immunization records | <input type="checkbox"/> other (specify) _____                  |

**Method of disclosure:**

- release medical records **from Hartsdale Medical Group, P.C.:**  
 180 East Hartsdale Avenue  
 Hartsdale, New York 10530  
 (914) 725-2010
- release medical records **to Digestive Disease & Nutrition Center of Westchester, LLP:**  
 Two Gannett Drive  
 White Plains, New York 10604  
 Phone: (914) 683-1555 Fax: (914) 683-1026  
 E-mail: records5@stomachmds.com

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: \_\_\_\_\_.

\_\_\_\_\_  
 Signature of Patient or Parent/Guardian/Executor

\_\_\_\_\_  
 Date

This form cannot be used for the re-release of confidential information provided to the Digestive Disease & Nutrition Center of Westchester by other individuals or agencies. Such requests should be referred to the original individual or agency. Records pertaining to HIV tests or discussions or alcohol/drug treatment require separate authorizations.

<b>Official Use Only</b>	<b>Scan with record when completed</b>
Completed by: _____ Date completed: _____	Delivery method: <input type="checkbox"/> FAXED <input type="checkbox"/> MAILED <input type="checkbox"/> IN PERSON <b>8/2008 RIR</b>