Authorization for Release of Medical Information

I hereby authorize CitiStorage, LLC, on behalf of Long Island College Hospital to release my protected health information to:

Name: _____

Email: _____

Patient Name: _____ Date of Birth: _____

Street Address: _____ Apt #: _____

City & State: _____ Zip Code: _____

Telephone Number: _____ Last 4 of SSN: _____

Treatment Dates: _____

(Only if known) _____

_____

Medical Record #: _____

(Only if known)

- ☐ Medical Records
- ☐ Radiology Films
- ☐ Mammography Films

I understand that this will be inclusive of all records pertaining to the above dates, regardless of content.

Signature of Patient ***OR*** _____ Date _____

Parent/Guardian _____ Date _____

This authorization must be signed by the patient, or in the case of a minor patient, authorization must be signed by parent or legal gardian. CitiStorage, LLC and LICH are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.