THE NEW YORK HOTEL TRADES COUNCIL
HEALTH CENTER, INC.
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

Request for Release of Medical Information

PATIENT INFORMATION

First Name* **MI** **Last Name*** **Date of Birth***

Phone Number*

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS

I authorize New York Hotel Trades Council Employee Benefit Funds Health Center Inc to disclose to*

☐ **Me** **or to** ☐ **Named person or entity**

Name* **Phone Number***

INFORMATION TO RELEASE

What to Release (check all that apply)*

☐ **Complete Record** ☐ **Radiology (X-Ray, MRI, etc.)**

☐ **Other (please specify)**

From Date* **To Date***

PICK-UP LOCATION

☐ **Harlem Health Center** ☐ **Midtown Health Center**

☐ **Brooklyn Health Center** ☐ **Queens Health Center**

DISCLOSURE OF SENSITIVE INFORMATION

I understand that this may include sensitive information relating to:

- Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.
- Behavioral health services/psychiatric care.
- Treatment for alcohol and/or substance use disorder.

Today's Date

Consent Expiration Date

30 Days after request date.

Signature

Printed Name