



*St. Alphonsus Family Medicine*  
*Dr. Maria A Cuda, D.O., P.C.*  
*P. O. Box 610*  
*Massena, NY 13662*  
Phone: 315-250-7946 [www.stafm.com](http://www.stafm.com)

# How to Request Your Medical Records

## *Instructions on requesting a copy of your medical records*

To request a copy of your medical records, you will need to complete the form, *Release of Medical Records*. One patient request per form; spouses and other family members who are also patients of Maria Cuda, DO will each need their own form completed, dated and signed. Please read the entire authorization form and complete all areas.

- *Records to be SENT TO* - Person or organization to receive your medical record information (example: Dr. John Brown). If the information is for yourself, you will need to complete this section with your name and address.
- *Patient Information*
- *My Authorization*
- *My Rights*
- *Notice Regarding Records Sent*
- If signed by a legal representative, a description of the representative's authority to act in your behalf

After filling out your form, use the  icon to print the form. Remember to sign and date the form before sending.

### **Please note the following:**

The authorization will be valid for 90 Days from the date of signature. *St. Alphonsus Family Medicine* charges for copies of health information in compliance with New York statutes.

### **All requested records will be sent on CD.**

- **First record request is free on CD** and additional CD copies will have a processing & handling fee of **\$25.00 per copy, payable in advance.**
- If you require **photocopies** instead of a CD, check the box on the form.
  - First record request or any additional photocopy requests will have a processing fee of .75¢ per page + postage, payable in advance.
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Submit the completed form and any applicable processing & handling fees (check or money order) to the following:

*Maria Cuda, D.O., P.C.*  
*St. Alphonsus Family Medicine*  
*PO Box 610*  
*Massena, NY 13662*



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SECTION: HIPAA     DATE: \_\_\_\_\_  
 TITLE: Final Request of Records  
 PROVIDER: MAC  
 NOTE: Medical Records sent to \_\_\_\_\_

**RELEASE OF MEDICAL RECORDS**

Records to be **SENT TO:** (if requesting to be sent to patient-address & phone still must be completed)

Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Phone (with area code) (    ) \_\_\_\_\_

Records to be **SENT FROM:**

**St. Alphonsus Family Medicine**  
**Maria Cuda, D.O., P.C.**  
**P. O. Box 610**  
**Massena, NY 13662**  
**Phone: (315) 250-7946**

**PATIENT INFORMATION** (One form per patient. Spouses and family members will each need to complete separate forms)

Name: \_\_\_\_\_  
 Telephone: (    ) \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_

**MY AUTHORIZATION**

**You may use or disclose the following health care information** (Check all that apply):

- All of my health information
- HIV (AIDS Virus) and/or Sexually Transmitted Diseases
- Psychiatric Disorders/Mental Health Issues, Drug and/or Alcohol Use
- Other: *Specific Dates or Condition(s)* \_\_\_\_\_

**Reason for this authorization**

- At my request

**This authorization ends in 90 days from date signed.**

**MY RIGHTS:**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Dr. Cuda's office based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

To revoke this authorization:

Write a letter to: *St. Alphonsus Family Medicine, Attn: Privacy Officer, PO Box 610, Massena, NY 13662*

Once Dr. Cuda's office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

**NOTICE REGARDING RECORDS SENT:**

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- Check here if you require **photocopies** instead of a CD. First record request or any additional photocopy requests will have a processing fee of .75¢ per page + postage, payable in advance. Additional photocopy requests will have a processing fee of .75¢ per page + postage, payable in advance.

**Print Full Name:** \_\_\_\_\_

**Signature of Patient or Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian  Power of Attorney for Healthcare  Other \_\_\_\_\_