Requests for Access to Health Information

If you wish to have CWRC release part or all of your medical records to you, please complete the Authorization for Release of Health Information Pursuant to HIPAA form. Please note that each partner must complete a separate request form.

All Medical Records Requests are completed within ten (10) days.

Please return a copy of the Authorization for Release of Health Information Pursuant to HIPAA form via mail or in person to:

Center for Women's Reproductive Care at Columbia University
Medical Records Department
1790 Broadway
4th Floor
New York, NY 10019

You may also fax your completed request to our office at 646-756-6293.

HIV Related Health Information
If you wish to have HIV related health information released, please indicate this on the release form with your initials.

Collecting Your Records
We will contact you once your medical records are ready for pick-up and will inform you of the cost at that time. We will provide you a copy of your records at a cost of $0.75 per page. Records are available for pick up Monday-Friday, from 9:00 am to 4:00 pm at:

Center for Women's Reproductive Care at Columbia University
Medical Records Department
1790 Broadway
4th Floor
New York, NY 10019

If someone is collecting your records on your behalf, you must provide a signed letter of authorization. This letter must contain: the name of the person you are authorizing to collect your records, your name, and your date of birth.

Please note that records are available on a pick-up basis only.

If you are a patient at our Westchester location please follow the instructions above and use the following address:

Center for Women's Reproductive Care at Columbia University
Medical Records Department
244 Westchester Avenue
Suite #209
White Plains, NY 10604

You may also fax your completed request to our office at 646-756-6287.