Westchester Medical Center
Authorization to Use or Disclose Protected Health Information

Patient Name: ______________________ **Medical Record #** (If known)**:** ___________

Name at time of Treatment (if different)**:** ____

Date of Birth: _____________________ **Social Security#** (last 4 digits only)**:** XXX-XX-____________

1. I authorize Westchester Medical Center to use or disclose the above named individual's health information as described below.

	Dates
❑ **Emergency Department**	________________________________
❑ **Outpatient (Describe)**	________________________________
❑ **Ambulatory Surgery**	________________________________
❑ **Inpatient Hospitalization**	________________________________

2. This authorization may include disclosure of information relating to ALCOHOL, DRUG ABUSE, MENTAL HEALTH TREATMENT, EXCEPT PSYCHOTHERAPY NOTES, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line in Item 4. In the event the health information described below includes any of this type of information, and I initial the line in Item 4, I specifically authorize release of such information to the person(s) indicated in Item 5.

3. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212)306-7450.

4. The information to be used or disclosed is as follows:
(check the appropriate boxes and INCLUDE THE APPROXIMATE DATES OF SERVICE)

❑ **Entire record**
❑ **Medical Abstract (pertinent medical information only)**
❑ **Photographs / Other Imaging**____
❑ **Other – (please describe)** ____

____

❑ **Include : (Indicate by Initialing)** _____________ **Alcohol/Drug treatment**
_____________ **Mental Health Information**
_____________ **HIV-Related Information**

5. Name and address of person(s) to whom this information is to be sent:

Name: ____

Address: ____

____

Name: ____

Address: ____

WMC/HIM Mailing address: **Westchester Medical Center**
Health Information Mgmt., Correspondence Section
Macy Pavilion, Room M18
Valhalla, NY 10595

6. **Revocation:** I understand that I have a right to revoke this authorization at any time, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department.

7. **Expiration Date:** Unless I specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCLOSE MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN PERSON(S) DESIGNATED IN ITEM 5

I have read this form and all of my questions have been answered to my satisfaction.
By signing this form, I acknowledge that I have read and accept all of the above.

____
Signature of Patient or Legal Representative

____
Date

____
Relationship to the patient,
if signed by Legal Representative,

Legal representative must attach copy of health care proxy, power of attorney, will & testament or other documentation indicating that you are a legal representative.

Fees

Copying films and distribution costs: We will charge you a reasonable fee to recover the costs of copying, mailing, and supplies used to fulfill your request. Our standard fee for copying is $0.75 per page. Copies forwarded to a physician are free of charge. A fee of $5.00 per sheet will apply to all X-Ray films copied.

NOTE: Please request copies of actual films (copied on CD) directly with the Radiology Dept.
Health Information Mgmt. does not store the films, only the radiology reports

Distribution of copies: Original to provider, copy to patient if requested, copy to accompany use or disclosure.
REV: 1/05
REV 6/06
Rev 11/07
Rev 2/09

WMC/HIM Mailing address: **Westchester Medical Center**
Health Information Mgmt., Correspondence Section
Macy Pavilion, Room M18
Valhalla, NY 10595