WMC Health
Westchester Medical Center Health Network

Authorization to Disclose Protected Health Information

IF NO LABEL: PRINT PATIENT'S LAST NAME, FIRST NAME, MR#, GENDER, DOB

Patient Name: _____ Medical Record # (If known): _____

Name at time of Treatment (if different): _____ Delivery method: Paper: ☐ Ext Drive: ☐ E-Delivery: ☐

Patient Address: _____ City/State: _____ Tele: _____

Date of Birth: _____ Zip Code: _____ email address: _____

Please select facility:

Home Care:

☐ - **Good Samaritan Home Care**

☐ - **Mid-Hudson Regional Home Care**

Name: _____

Address: _____

Phone: _____ Fax: _____

Email or alternative contact information: _____

Description of Information to be disclosed: *(check the appropriate boxes)*

☐ All Medical Records, including history, test results, genetic information, referrals, consults (*excluding* alcohol/drug treatment, HIV-related information, mental health treatment and psychotherapy notes)
- ☐ Include radiology studies, films and images, fetal monitoring strips
- ☐ Include billing & insurance records
- ☐ Include records sent to WMC Health Network Facility by other health care providers

☐ Medical Records from (date): _____ to _____

☐ Medical Record Abstract (*pertinent medical information only*)

☐ Other (please describe): _____

☐ I authorize the release of the following records (please initial):
- _____ Alcohol/Drug Treatment Information
- _____ HIV-Related Treatment Information
- _____ Psychotherapy Notes (*if yes, please complete additional authorization for this purpose)*
- _____ Mental Health Treatment Information (*excluding psychotherapy notes*)
- _____ Genetic Testing/Documentation
- _____ Plan of Safe Care

Purpose of Disclosure: ☐ Continuing Care ☐ Insurance ☐ Legal ☐ Self ☐ Other _____

This authorization will expire one year (or 6-months in the case of the Plan of Safe Care) from the date on which it was signed if no expiration date or event is indicated: (*Please note desired expiration date or event, if any*) _____

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1. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing 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.

2. I understand that any disclosure/release is bound by Title 42 if the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and accountability act of 1996 (HIPAA) 45 C.F.R. pts 160 & 164; and re-disclosure of this information to a party other than one designated above is forbidden without written authorization on my part.

3. WMC Health Network facilities will not condition treatment or payment on your signing this authorization.

4. The information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected

5. I understand that I have a right to revoke this authorization at any time, except to the extent that any of the facilities above have 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 of WMCHealth Network, at 100 Woods Road, Macy Pavilion, Room M18, Valhalla, New York 10595 (Phone: 914-493-7600)

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.

_____ _____

Patient Signature *Date*

For child: I hereby declare that I am the natural, or adoptive parent or a legal guardian of the above-named child and there is no court order restricting or prohibiting my access to the indicated records:
Other Legal Representatives must attach copy of health care proxy, power of attorney, will & testament or other documentation:

Indicate Relationship to Patient:_____

_____

Signature *Print Name* *Date*