



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: ___ CD: ___ Ext Drive: ___ Email: ___

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

Date of Birth: _____ Zip Code: _____

I authorize MHRH of Westchester Medical Center to disclose the above-named individual's health information as follows:

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

Name: _____

Address: _____

Phone: _____ Fax: _____

Email or alternative contact information: _____

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

- Medical Records, including history, test results, genetic information, referrals, consults...
Include radiology studies, films and images, fetal monitoring strips
Include billing & insurance records
Include records sent to MHRH of WMC 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
Mental Health Treatment Information
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)

- 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.
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. MHRH of Westchester Medical Center does 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 MHRH of Westchester Medical Center has already acted in reliance on it.



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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

Fees: **We will charge you a reasonable fee to recover the costs of copying, mailing, and supplies used to fulfill your request. Copies forwarded to a physician are free of charge.**