



Health Information Management Department
Tel: (914) 682-6416 Fax: (914) 682-6415
medicalrecords@westmedgroup.com

Instructions for Completing the Authorization for Release of Health Information

Patients/Representatives need to carefully read and complete every section prior to signing and dating the form to ensure a valid and complete authorization is received.

1. Patient Information:

Please fill out all patient information that is listed (Name, Phone number, Date of birth, Address, City, State, and Zip Code).

2. Authorize Medical Information:

- A. Designate what doctor office, and/or physician (s) will be releasing (copying and sending) the medical records.
- B. List the name, address, and phone number of the organization or person to whom you want the records sent.

3. Description/Records to be released:

- A. Please list the dates of service of the records you want released. (Dates the patient was seen at the doctor's office or clinic.)
- B. Please be specific as to what part of the medical record is being requested, or specify "entire Medical Record"
- C. If you wish to include sensitive information in your request you must indicate by initialing this section

4. Reason/Purpose:

- A. Check the reason you are giving permission for the records to be released.
- B. Authorization Expiration: Authorizations expires in 6 months unless other date is specified. (You may leave this section blank)

5. To be read and signed by patient:

- A. Read the Patient Rights statements.
- B. Select the format you prefer to receive the information, paper, CD/DVD, EMAIL (file size limitations).
- D. Sign and date the form to confirm the release of medical information.

****Please note that a fee may be charged for copying the records****

****Please print clearly and refrain from strike outs****

****We cannot accept electronic or voice signatures at this time****

****If you are not the patient, then please provide a copy of appropriate legal documentation**

6. Obtaining Your Medical Record:

Medical Records will be mailed or emailed to the address indicated on the authorization. If there is a copy fee, then an invoice will be emailed or mailed to the address and records will be sent once payment is received.

****We accept checks, money orders, or pay by phone with a credit card****

If you would like to pick up your medical records in person, we offer this option for limited information (less than 15 pages of records) at certain locations. Please visit our website for a list of locations and hours of operation.



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AUTHORIZATION For the Release of Medical Information

Patient Name: _____ Phone: _____ Date of Birth: _____ EMAIL: _____

Patient Address: Street, City, State, Zip _____ MRN: _____

I hereby authorize WESTMED Medical Group to release my medical information to:

Name: _____ Attention of: _____

Address: Street, City, State, Zip _____

Dr. _____ OR All providers at WESTMED Medical Group

Description of information to be released (Please be specific and include dates): _____

Abstract (includes office notes, labs, radiology reports, diagnostic test results, pathology results): _____

Entire Record (may take up to 10 days for processing) in addition to an abstract includes (indicate by checking box):

_____ Billing Records _____ Phone Notes _____ Patient Emails _____ Outside Records from other providers
 _____ Alcohol/Drug Treatment _____ HIV-Related information and test results _____ Mental Health Treatment (except psychotherapy notes)

REASON FOR REQUESTED USE OR DISCLOSURE:

Personal Use Legal Second Opinion Change in health care provider Workers Compensation

Other (specify) _____

This authorization expires in 6 months from date signed if no expiration date/event is otherwise indicated here: _____

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

- a. I may revoke this authorization at any time by providing written notice to the practice.
- b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- c. The practice will not condition treatment or payment based on my signing this authorization.
- d. I am signing this authorization freely and under no pressure from any individual to do so.
- e. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
- f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use. My questions about the form have been answered to my satisfaction.
- g. This is a full authorization and may include disclosure of information relating to ALCOHOL, DRUG ABUSE, CONFIDENTIAL HIV RELATED INFORMATION and MENTAL HEALTH TREATMENT (except psychotherapy notes). If I am authorizing the release of HIV-related, alcohol, 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 of HIV-related information, I may contact the NYS Division of Human Rights at (212) 480-2493 or CT Commission on Human Rights and Opportunities at (800) 477-5737. These agencies are responsible for protecting my rights.
- h. I may inspect and/or receive a copy of the information authorized for release pursuant to this authorization.
- i. My medical records may contain genetic testing information including test results.

FORMAT: please select only one (Fees may Apply) Paper Copy CD/DVD Encrypted EMAIL (file size limitations apply)

Radiology Image Duplication Fees: \$15 per film \$5 per CD + cost of mailing \$5 for echocardiogram CD or nuclear medicine CD

Patient Signature _____	Date _____	<input type="checkbox"/> I acknowledge receipt of records _____ INITIAL
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For a child: I hereby declare that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

Signature of Patient's Representative _____	Relationship _____	Date _____
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OFFICE USE ONLY:

I.D. Verified: Type _____ Initials _____

RELEASE OF MEDICAL RECORD FEE STRUCTURE

Release to Patient or Patient Representative:

Paper Delivery

1-15 pages	Free
16-50 pages	\$6.50 includes supplies and postage
>50 pgs.	\$0.20 per page includes supplies & postage fees **

Digital delivery (Encrypted Email/CD/DVD)

- *File size limitations may apply to email.*

1-15 pages	Free
16-100 pages	\$6.50 includes supplies & postage
>100	\$0.08 per page includes supplies & postage**

Mammography Images	Free
Radiology Images	\$5.00
Cardiology Images	\$5.00
Radiology Duplication	\$15.00 per film

My WESTMED Free-Patient portal direct 24/7 access to some lab and radiology results (those tests ordered and performed by a WESTMED provider) & medication and allergy list.

Release to Third Party:

Paper and Digital Delivery (Paper, Encrypted Email/CD/DVD/Third Party Portal)

\$0.65 per page*

Direct Release to Physicians for ongoing patient care:

Free for both Digital and Paper Delivery**

***Additional charges may apply for UPS tracking and UPS rush shipping.*