WESTMED MEDICAL GROUP
Health Information Management Department
2700 Westchester Ave., Purchase, NY 10577
Tel: (914) 682-6416 Fax: (914) 682-6415
medicalrecords@westmedgroup.com

AUTHORIZATION
For the Release of Medical Information

Patient Name: Jane Doe | Phone: 555-555-5555 | Date of Birth: 01/15/1900 | EMAIL: JD@yahoo.com

Patient Address: Street, City, State, Zip: 123 Hill Drive New York, NY 10010 | MRN:

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

Name: Yonkers Eye Assoc | Attention of: Dr. Smith

Address: Street, City, State, Zip: 777 Doc Avenue Yonkers, NY 11151

(If you would like us to email your records to someone other than you, print their email address here)

☒ **Dr.** (Westmed providers name here) OR ☐ **All providers at WESTMED Medical Group**

☒ **Description of Information to be released** (Please be specific and include dates): Labs from 2016

☐ **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, CONFIDENTAL 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 Jane Doe (written signature)	**Date** 12/1/2017	☐ I acknowledge receipt of records _____ INITIAL
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

OFFICE USE ONLY:

☐ I.D. Verified: Type _____ Initials _____