REQUEST FOR MEDICAL INFORMATION

Patient Name:

Patient Address:

Medical Record #: Date of Birth: MM DD YY

I am the above named patient, and I am under the care of Westmed Medical Group. I hereby authorize the below provider to disclose my protected health information (information pertaining to my medical records and/or financial records) as indicated below:

(Fill in name and complete address of medical provider from whom information is being requested.)

Name: _____ Street: _____

City, State & Zip Code: _____

THIS INFORMATION IS TO BE DISCLOSED TO: Westmed Medical Group, _____
AT THE FOLLOWING ADDRESS: 2700 Westchester Avenue, Purchase, NY 10577 (Insert Physician Name)

☐ Description of Information to be released: _____

☐ Medical Records from _____ to _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Include (indicate by initialing): _____ **Alcohol/Drug Treatment** _____ **HIV-Related Information and test results**

_____ **Mental Health Treatment** (Except psychotherapy notes)

Dr. _____ ☐ All providers

REASON FOR REQUESTED USE OR DISCLOSURE:

☐ Personal use ☐ Legal ☐ Second opinion ☐ Change in health care provider

☐ Other (specify) _____

This authorization expires in 6 months from date signed if no expiration date/event is indicated. _____
EXPIRATION DATE OR EVENT

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 authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, and CONFIDENTIAL HIV RELATED INFORMATION and MENTAL HEALTH TREATMENT (except psychotherapy notes) only if I place my initials on the appropriate box above, I specifically authorize release of such information to the person(s) indicated.
h. 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-related 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. These agencies are responsible for protecting my rights.
i. I may inspect and/or receive a copy of the information authorized for release pursuant to this authorization.
j. My medical records may contain genetic testing information including test results.

Patient Signature		Date
Signature of Patient's Representative	Relationship	Date