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, Email, Address, City, State, and Zip Code).

2. List the name, address, email (optional), and phone number of the organization or person to whom you want the records sent.

3. Description/Records to be released: Please list the dates of service of the records you want released and the physician's name. Or select all providers at Westmed. Abstract will consist of the two most recent years of medical records.

4. Select the format you prefer to receive the information, paper, CD/DVD, EMAIL (file size limitations).

5. Sign and date the form to confirm the release of medical information.

Medical Records can also be viewed and requested through my westmed. Records requested via my westmed will only be delivered to the requestor's my my westmed account. Please note that radiology images cannot be ordered from or sent to a my westmed account.

For additional information related to medical records please visit our website at
https://www.westmedgroup.com/patient-info/my-medical-records/

westmed
A Summit Health Company
Health Information Management Department
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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: _____ EMAIL: _____
Address: Street, City, State, Zip

_____ Phone_____

☐ **WESTMED 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, 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	**Date**	☐ 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 _____