WMC Health | HealthAlliance
Westchester Medical Center Health Network

Authorization to Disclose Protected Health Information IF NO LABEL: PRINT PATIENT'S LAST NAME, FIRST NAME, MR#, GENDER, DOB

INSTRUCTIONS FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

1. Please complete the Authorization to Disclose Protected Health Information pages 2 and 3, addressing all required information. **Do not leave any blanks on the form**. This will result in delays with processing your request.

2. Make sure to specify the required information needed, otherwise, all records will be mailed.

   There is copy service fee per page for patient access of their records. An invoice for copies of records will be mailed out by the copy service to the recipient on the authorization form. If the patient's records are being sent to a medical provider, unless otherwise specified, all pertinent medical records for continuity of care will be sent at no charge.

3. Once form is completed and signed, please return to the HealthAlliance Hospital Health Information Management (HIM Department) for processing.

Please forward completed release forms to the following: (Mail or Fax ONLY. Do not send both):	
Fax	Health Information Management (HIM) - 845-331-7860 For films on CD, forward to **Radiology**: Fax 845-334-2788 Phone 845-334-2774
Mailing Address	HealthAlliance Hospital Attn: Health Information Management 396 Broadway, Kingston, NY 12401 Attn: Radiology (for films ONLY)

MEDICAL PROVIDERS: (i.e., Medical Facilities; Providers; Caregivers; Doctor's Offices; Hospitals, etc.)
Please make requests on official office/facility letterhead. A signed release by patient or legal representative is required if the medical records contain federally protected information.

IMPORTANT:
Regardless of how the records are received, the ***recipient's*** mailing address must be included

Recipient is the one receiving the records (not necessarily the patient or requester)

Thank you.

HIM Department, HealthAlliance Hospital
Phone: 845-334-2777 fax 845-331-7860

WMC Health | HealthAlliance
Westchester Medical Center Health Network

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:_____ Email:_____

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

Date of Birth:_____ Zip Code: _____

I authorize HealthAlliance Hospital 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)*

- ❑ All Medical Records from HealthAlliance Hospital: Broadway Campus
- ❑ All Medical Records from HealthAlliance Hospital: Mary's Avenue Campus
- ❑ All Medical Records from Margaretville Hospital

- ❑ All Medical Records, including history, test results, genetic information, referrals, consults (*excluding* alcohol/drug treatment, HIV-related information, mental health treatment and psychotherapy notes)
  - ❑ Include radiology studies, films and images
  - ❑ Include billing & insurance records
  - ❑ Include records sent to HealthAlliance Hospital 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 (*if yes, please complete additional authorization for this purpose)*
  - _____Mental Health Treatment Information (*excluding psychotherapy notes*)

Purpose of Disclosure: __Continuing Care __Insurance ___Legal ___Self ___Other_____

This authorization will expire one year 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. 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 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.

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. HealthAlliance Hospital does not condition treatment or payment on your signing this authorization.

Authorization to Disclose Protected Health Information IF NO LABEL: PRINT PATIENT'S LAST NAME, FIRST NAME, MR#, GENDER, DOB

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 has already acted in reliance on it. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department of HealthAlliance Hospital, at 396 Broadway, Kingston, New York 12401 Phone: 845-334-2777 fax 845-331-7860

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.**