WMC Health | HealthAlliance
Westchester Medical Center Health Network

Patient Label

Authorization to Disclose Protected Health Information − Page 1 of 2

Patient Name: _____ Medical Record # (If known): _____

Name at time of Treatment (if different): _____ 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: _____

Other or alternative contact information: _____

Description of information to be disclosed: *(check the appropriate boxes)*

- ❑ Entire record, including history, test results, genetic information, images, referrals, consults, billing & insurance records (*excluding* alcohol/drug treatment, HIV−related information, mental health treatment and psychotherapy notes)
- ❑ 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 of 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 my signing this authorization.

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 HealthAlliance Hospital 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: 845−331−3131)

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Authorization to Disclose Protected Health Information – Page 2 of 2

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/Time*

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 a copy of health care proxy, power of attorney, will & testament or other documentation:

Indicate Relationship to Patient: _____

_____ _____ _____

Signature *Print Name* *Date/Time*

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.**