AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

WESTFIELD FAMILY PHYSICIANS, PC

☐ 138 E Main Street | PO Box 10 | Westfield, NY 14787 | phone 716.326.4678 | fax 716.326.4641

☐ 115 E Main Street | PO Box 570 | Sherman, NY 14781 | phone 716.761.6144 | fax 716.326.4641

1. Patient's name: | 2. Date of Birth:

3. Patient's address: Phone number:

I, or my legally authorized personal representative, request that health information regarding my care and treatment be disclosed as set forth on this form. In accordance with New York State law and the Privacy Rule of the Health Information Portability and Accountability Act (HIPAA) of 1996, I understand that:

This authorization may include disclosure of information relating to ***records from alcohol/drug treatment programs, records from mental health programs,*** and confidential ***HIV/AIDS-related information*** only if I place my initials on the appropriate line in box 5 below. In the event the health information described below includes any of these types of information, and I initial the items in box 5, I specifically authorize disclosure of such information to the person or persons indicated in box 7. If I am authorizing the disclosure of records from alcohol/drug treatment programs, mental health programs, and confidential HIV/AIDS-related information, that recipient is prohibited from redisclosing such information about my authorization unless permitted to do so under federal or state law. If I believe my rights have not been protected, I may contact the New York State Division of Human Rights at 1.888.392.3644.

This authorization is voluntary and I have the right to refuse to sign it. My treatment will not be conditioned upon my authorization of this disclosure.

I have the right to revoke this authorization at any time by writing to the healthcare provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Information disclosed might be redisclosed by the recipient except as noted above, and this redisclosure may no longer be protected by Federal or state law.

This authorization does not authorize disclosure of my health information or medical care with anyone other than the person or persons specified below in box 7.

I may be charged a fee of up to $0.75 per page if I am requesting a copy of my records for my own personal use.

4. I authorize the disclosure of health information (written or oral) of the individual named above (in box 1) for the following purpose:

- O for medical care
- O to transfer care to another healthcare provider
- O to share health information with another individual
- O for insurance purposes
- O for billing purposes
- O other (please describe): _____

5. The type of information to be disclosed is as follows. Please check the appropriate items below:

- O last 2 years of records
- O lab and/or x-ray results
- O immunization records
- O other, please describe: _____

Include (indicate by initialing)

_____ ***Records from alcohol/drug treatment programs***

_____ ***Clinical records from mental health programs***

_____ ***HIV/AIDS - related information***

6. Please disclose the information above **FROM:**

Healthcare Provider: _____ O Individual (relationship): _____

Address: _____ O Organization: _____

Phone: _____ Address: _____

Fax: _____ Phone: _____

Fax: _____

7. Please disclose the information above **TO Westfield Family Physicians**

Note: Westfield Family Physicians can receive electronic CCDs at this address: practice@wfp.medentdirect.com

8. Unless previously revoked by me, the specific information authorized here may be disclosed from _____ (start date) until _____ (expiration date) or _____ (expiration event).

9. _____ _____

Signature of patient or personal representative authorized by law | Date

_____

If personal representative, relationship to patient (please print)

FOR OFFICE USE ONLY:

Action taken | Employee initials | Date: _____