AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Westfield Family Physicians, PC

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

O 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 ***alcohol and drug abuse***, ***mental health treatment*** (except psychotherapy notes), and confidential ***HIV-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 6B. If I am authorizing the disclosure of HIV-related, alcohol or drug treatment, or mental health treatment information, that recipient is prohibited from redisclosing such information about 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 believe my rights have not been protected, I may contact the New York State Division of Human Rights at 212.480.2493.

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 you to discuss my health information or medical care with anyone other than the person or persons specified below in box 6.

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 of the individual named above for the following purpose:

- O to transfer care to another healthcare provider
- O for medical care
- O other (please describe): ______________________

5. The type of information to be disclosed is as follows. Please check the appropriate items below (all subject to expiration below):

- O entire health record (include consult notes) - last 2 years
- O lab and/or x-ray results
- O immunization records
- O other, please describe: ______________________

Include (indicate by initialing)

- _________ ***Alcohol / Drug Treatment***
- _________ ***Mental Health Information***
- _________ ***HIV-Related Information***

6A. Please disclose the information above **TO Westfield Family Physicians**

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

Healthcare Provider / Hospital: ______________________

Address: ______________________

Phone: ______________________

Fax: ______________________

7. Select one of the following two choices:

- O This authorization will expire on the following date: ________/_________/___________
- O This authorization will expire when the following event happens.

Event: ______________________ (must relate to the individual in box 1)

8. X ______________________ ______________

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: ______