The Westchester Medical Group

Dear Requestor:

The Westchester Medical Group is unable to process the enclosed authorization because it is not HIPAA compliant. Section 164.508 of the federally mandated HIPAA Privacy Rule states that a valid authorization must contain the following:

Name and identification of the individual whose protected health information is to be disclosed

Specific description of the protected health information to be used or disclosed (i.e. types of reports and dates of service)

Name of person(s) or group to whom the information may be disclosed

Description of the purpose of the requested use or disclosure (why the information is being disclosed)

An Expiration date or event indicating when the authorization will expire

Statement indicating the authorization may be revoked

Statement about the ability or inability of the covered entity to condition treatment, payment, enrollment or eligibility for care based on the authorization

Statement indicating that there is a potential for protected health information to be re-disclosed by the recipient and it is no longer covered under the Privacy Rule

Signature of individual and date. If the personal representative of the individual signs the authorization, a description of the representative's authority to act on behalf the individual is also required

Enclosed is a valid authorization containing all of the above elements. Once we receive the authorization The Westchester Medical Group will release the records.

Sincerely,

Correspondence Clerk
Health Information Management Department

The Westchester Medical Group

Health Information Department
210 Westchester Ave., White Plains, NY 10604
Tel. 914-682-6416 • Fax 914-682-6415

AUTHORIZATION
For The Release of Medical Information

Patient Name: | Phone Number:

Patient Address:
Street, City, State, Zip

Medical Record #: | Date of Birth: MM DD YY

Other Identifier (Social Security Number):

"I hereby authorize The Westchester Medical Group to make uses and disclosure of my protected health information (information pertaining to my medical records and/or financial records) as indicated below."

THIS INFORMATION IS TO BE DISCLOSED TO:

Name: _____

Attention of: _____

Street Address: _____

City / State / Zip: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____

_____

For dates of treatment from _____ to _____

REASON FOR REQUESTED USE OR DISCLOSURE:

☐ Transfer of health coverage ☐ Personal Use ☐ Form Completion ☐ Referral ☐ Change in health care provider
☐ Other Event _____

This authorization expires in 6 months from the date signed or earlier _____ .
STATE DATE

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.
g. I will receive a copy of this completed and signed authorization form.

Medical Records Copying Fees: 75¢ per page plus cost of mailing.
Radiology Duplication Fees (please choose): ☐ **Film, $15.00 per film plus cost of mailing** ☐ **CD, $5.00 per CD plus cost of mailing**

Patient Signature		Date
Signature of Patient's Representative	Relationship	Date

OFFICE USE ONLY:
☐ I.D. Verified: Type _____ Initials _____

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