Health Information Management Department
Tel: (914) 682-6416 Fax: (914) 682-6415
medicalrecords@westmedgroup.com

Instructions on how to request outside records to be transferred to your Westmed provider.

Patients/Representatives need to carefully read and complete every section prior to signing and dating the form to ensure a valid and complete authorization is received.

1. Patient Information: Please fill out all patient information that is listed (Name, Phone number, Date of birth, Address, City, State, and Zip Code).

2. Select the method of delivery: Mail, E-mail or Fax.

3. List the name of the practice/physician and address of the entity that is to release records to Westmed.

4. Description/Records to be released: Please list the dates of service of the records you want released and the physician's name.

5. Sign and date the form to confirm the release of medical information.

6. Patient is responsible for sending the completed form to their outside provider for processing, once Westmed receives the records they will be added to the patient chart.

REQUEST FOR MEDICAL INFORMATION TO BE SENT TO WESTMED

Patient Name:	Date of Birth: MM	DD	YYYY
Patient Address:			

THIS INFORMATION IS TO BE SENT TO: Westmed Medical Group Attn: Medical Records Department VIA THE FOLLOWING METHOD (please select one):

☐ MAIL ☐ Email: medicalrecords@westmedgroup.com ☐ Fax: 914-682-6415

Westmed Health Information Management Dept.
800 Westchester Avenue, Suite N-715
Rye Brook, NY 10573

I am the above named patient, and I am under the care of Westmed Medical Group. I hereby authorize the below provider to disclose my protected health information (information pertaining to my medical records and/or financial records) as indicated below:

Address of Non Westmed medical provider from whom information is being requested

Name of Practice/Physician:_____Street: _____

City, State & Zip Code: _____

Phone:_____ _____ Fax:_____

☐ Description of Information to be released: _____

☐ Medical Records from (date range)_____to _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Include (indicate by checking box): ___ Alcohol/Drug Treatment ___ HIV-Related information and test results ___ Mental Health (excluding psychotherapy notes)

_____

This authorization expires in 6 months from date signed if no expiration date/event is indicated. _____
EXPIRATION DATE OR EVENT

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. My questions about the form have been answered to my satisfaction.
g. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, and CONFIDENTIAL HIV RELATED INFORMATION and MENTAL HEALTH TREATMENT (except psychotherapy notes) only if I place my initials on the appropriate box above, I specifically authorize release of such information to the person(s) indicated.
h. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing 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-related 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. These agencies are responsible for protecting my rights.
i. I may inspect and/or receive a copy of the information authorized for release pursuant to this authorization.
j. My medical records may contain genetic testing information including test results.

Patient Signature		Date
Signature of Patient's Representative	Relationship	Date