Northern Westchester Hospital
Northwell Health℠

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____Date of Birth:_____

Telephone #: _____ Medical Record #:_____

I hereby authorize the _____ Department at Northern Westchester Hospital to use or disclosure the above
(specify Department)
named individual's health information as described below:

I wish to (view/receive) copies of my records. (circle one)
The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

____ Face Sheet ____ Most Recent Discharge Summary
____ Most Recent History & Physical ____ Emergency Dept Record (date) _____
____ Consultation Report (date) _____doctors name:_____
____ Operative Report (date) _____doctors name:_____
____ Radiology Reports from (date)_____ to (date) _____
____ Radiology Films from (date)_____ to (date) _____
____ Pathology Slides/Blocks from (date)_____ to (date) _____
____ Laboratory/Test Result from (date)_____ to (date) _____
____ EKG/Echo/Stress Test from (date)_____ to (date) _____
____ Abstract from (date) _____ to (date) _____
(discharge summary, H&P, progress notes, procedures, consults, test results)
____ Billing Record from (date) _____ to (date_____
____ Other (specify)_____

This information may be disclosed to and used by the following individual or organization:
_____ Self _____Other (specify)_____
Address:_____
Telephone Number:_____Fax Number:_____
For the purpose of:_____

I understand that I will be charged for the copying and postage of my records prior to release. The cost incurred will depend upon the number of pages requested.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that NWH will not condition my treatment on the signing of this form. I understand I may inspect the information to be used or disclosed, as provided in 45CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Description of Authority

Health Information Management Staff/Copy Service Use Only
DATE MAILED/FAXED/RELEASED IN PERSON_____
(CIRCLE ONE) INITIALS_____

FORM MUST BE FILLED OUT IN FULL TO BE VALID

RETURN FAX # (914) 666-1013