Westfield Family Physicians, PC
Great Lakes Medical Research, LLC
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 716.761.6156

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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 for medical care
   - O for insurance purposes
   - O to transfer care to another healthcare provider
   - O to share information with a family member or caregiver
   - O other (please describe): _____

5. The type of information to be disclosed is as follows. Please check the appropriate items below:
   - O immunization records
   - O lab and/or x-ray results
   - O entire health record (last two years unless otherwise noted)
   - O other, please describe: _____

   Include (indicate by initialing)
   - _____ ***Alcohol / Drug Treatment***
   - _____ ***Mental Health Information***
   - _____ ***HIV-Related Information***

6A. Please disclose the information above **FROM**
- O Westfield Family Physicians / Great Lakes Medical Research
- O Other, please complete the lines below

Individual / Organization: _____
Address: _____

6B. Please disclose the information above **TO**
- O Westfield Family Physicians / Great Lakes Medical Research
- O Other, please complete the lines below

Individual / Organization: _____
Address: _____

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. The event must relate to the individual or the purpose of the authorized disclosure.
     Describe the event: _____

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 signature _____ Date _____