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Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 requires that you, or your legal representative, consent in writing to the disclosure of your protected health information and medical records. This form authorizes the release of your protected health information. By signing this form, your protected health information can be given to the individuals and/or entities listed on the form, for the reasons listed in this form.

Please read all statements on this form carefully, as it describes your right regarding the use or disclosure of your protected health information and medical records that are subject to this authorization.

I, _____, authorize _____

(the "Covered Entity") to disclose to: _____

address _____, (Name of entity receiving

information) the following protected health information: _____

(Please describe specifically the information to be used or disclosed by dates, condition, treatments, etc.)

The protected health information and medical records covered by this authorization may be used for the following purposes: _____

(Please describe the purposes for which the protected health information will be used or disclosed)

This authorization will remain effective until _____ (Please specify date for authorization to expire)

I understand that I have the right to revoke this authorization, in writing, at any time (except to the extent that the Covered Entity has acted in reliance upon this authorization) by sending notification to: _____

I understand that a revocation will prevent the Covered Entity from further use or disclosure of my protected health information, but it will not retract the uses or disclosures that have already been made pursuant to the authorization. Revocations will not be effective to the extent that the Covered Entity has taken action based on the authorization, or, if the authorization was a condition for obtaining insurance coverage, to the extent applicable law allows the insurer to contest a claim under the policy.

I understand that the protected health information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

I understand that the Covered Entity cannot condition my enrollment or eligibility for benefits based upon whether I sign this authorization.

I understand that I have the right to inspect and copy the protected health information and medical records covered by this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted disease, tuberculosis or genetics.

IF YOU DO NOT WISH THIS INFORMATION NOTED THE PRECEDING PARAGRAPH TO BE RELEASED, PLEASE INITIAL - DO NOT RELEASE _____

By signing below I acknowledge that I have read and understand my rights relating to this authorization for the use or disclosure of my protected health information and medical records.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Nature of Personal Representative's Authority