WESTCHESTER MEDICAL CENTER

WORLD-CLASS MEDICINE THAT'S NOT A WORLD AWAY.

WESTCHESTER MEDICAL CENTER
DEPARTMENT OF ANATOMIC PATHOLOGY
100 Woods Road
Valhalla, NY 10595

PHONE: 914-493-7394
FAX: 914-493-1145

AUTHORIZATION TO RELEASE SLIDES/BLOCKS & PATHOLOGY REPORTS

To: WESTCHESTER MEDICAL CENTER Re: _____
(Patient Name)

Patient Phone #:_____ Patient Signature: _____
(Or Authorized Representative)

Date: _____

Office Hours: 8:30 AM to 4:30 PM Monday-Friday

This message is intended only for the individual or entity to whom or to which it is addressed and may contain information that is PRIVILEGED, CONFIDENTIAL, AND EXEMPT FROM DISCLOSURE under applicable law. If the reader of the message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and return the original communication to me at the address shown above by regular mail United States Postal Service. Thank you.

Please indicate the manner by which you want the requested slides/blocks/reports be handled:

( ) Send to patient's address

(X) Send to doctor's office

Doctor's name: _____
Doctor's address: _____
_____
Doctor's phone #: _____

MD Anderson Cancer Center
Pathology Department, Unit #85
Room G1-3669
1515 Holcombe Boulevard
Houston TX 77030

FOR PROCESSING OF SLIDES, PLEASE ALLOW 48 HOURS (2 DAYS) UPON RECEIPT OF REQUEST

PLEASE NOTE: Department processing fees are as follows:

( ) Patient pick up ($25.00)
( ) First Class Mail/Certified/Return Receipt ($25.00)
( ) Fed Ex ($25.00 plus additional fee of $18.00 – total $43.00)

It is the responsibility of the patient to have the slides/blocks returned to Westchester Medical Center. NYSDOH regulations require that WMC keep slides/blocks for 20 years from date of accessioning.

Please also fill out the attached HIPAA form and fax both pages back to us at 914-493-1145.

Authorization form and HIPAA form must be completed in their entirety; otherwise, we cannot process your request.

OCA Official Form No. 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. 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 Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. 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.
3. I have the right to revoke this authorization at any time by writing to the health care 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.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:
Westchester Medical Center, Department of Pathology, 100 Woods Road, Valhalla, NY 10595

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a): Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

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

☒ Other: _____

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

(X) _____ Date: _____

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.