



WESTMED

MEDICAL GROUP

The Future of Healthcare Today
Health Information Management Department
2700 Westchester Avenue, Purchase, NY 10577
Fax: (914) 682-6415

AUTHORIZATION To Verbally Communicate Protected Health Information

Patient Name: _____ Phone Number: _____

Patient Address:
Street, City, State, Zip _____

Medical Record #: _____ Date of Birth: _____
MM DD YY

"I hereby authorize WESTMED Medical Group to verbally disclose my protected health information (information pertaining to my medical records and/or financial records) as indicated below."

THIS INFORMATION CAN BE COMMUNICATED TO (Relationship):
 Spouse Child Friend Other _____ Spouse Child Friend Other _____

Name _____ Name _____

Street Address _____ Street Address _____

City, State, Zip _____ City, State, Zip _____

Phone _____ Phone _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:
 Physician may communicate medical information to the above person. WESTMED may communicate financial information regarding my treatment.
 Lab/Radiology results (Limited to verbal discussions only with my Health Care Providers) Information limited to _____
 Other _____
For dates of treatment from _____ to _____
 All medical/financial information. Information limited to _____

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 WESTMED.
b. I may not be able to revoke this authorization if WESTMED has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. WESTMED 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. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
f. I will receive a copy of this completed and signed authorization form.

Patient Signature _____ Date _____

Signature of Patient's Representative _____ Relationship _____ Date _____

OFFICE USE ONLY:
 I.D. Verified: Type _____ Initials _____