WESTMED
MEDICAL GROUP
The Future of Healthcare Today
Health Information Management Department
2700 Westchester Avenue, Purchase, NY 10577
Fax: (914) 457-1400

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.

□ Pick-up lab/radiology results (including films and CDS)

□ 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. WESTMED will not condition treatment or payment based on my signing this authorization.
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 _____