Four Winds Hospital

PATIENT NAME:

DATE OF BIRTH:

Authorization for Release of Information

FOUR WINDS HOSPITAL

Please forward the request to the location you wish to obtain from/release to:

Westchester
800 Cross River Road
Katonah, NY 10536
Phone: (914) 763-8151
Fax: (914) 763-0950

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600
Fax: (518) 580-1514
Partial Fax (518) 581-2535

I authorize Four Winds Hospital to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

Or ☐From Date: _____ To Date: _____

Unless a period is specified, the information below will be provided from the most recent hospital location admission only

The Specific Information to be Disclosed is:

- ☐ Diagnosis Only
- ☐ Dates of admission and/or discharge
- ☐ Integrated Assessments/Psychiatric Assessment
- ☐ Discharge Summary
- ☐ Verbal/Written Communication for Discharge
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):_____

This information will be used for the following purpose(s):

- ☐ Evaluation and Continuing Treatment / Coordinating Care
- ☐ Educational Placement / Other Educational Concerns / Billing School District for Education
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):_____

Four Winds Hospital is a two hospital system comprised of both Four Winds Westchester and Saratoga inpatient hospitals, partial hospitalization programs, and intensive outpatient programs. I understand authorizing this disclosure applies to both hospitals at every level of care. I understand that a separate authorization form is not needed to exchange protected health information between both hospitals at every level of care for the purposes of treatment, payment, and operations.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing 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.

Signature of Patient or Legal Guardian	Relationship to Patient	Date

HIM: document all disclosures in Disclosure Management