WMC Health | Bon Secours Medical Group
Westchester Medical Center Health Network

Date: _____

Print Name: _____ DOB: _____/_____/_____

**List of Physicians and Consultants You are Seeing**

| Consultant | Name (S) |
|---|---|
| Cardiology (Heart) | |
| Pulmonary (Lungs) | |
| Gastroenterology (Stomach) | |
| Nephrology (Kidney) | |
| Neurology (Brain) | |
| Endocrinology (Diabetes-Thyroid) | |
| Oncology (Cancer) | |
| Gynecology (Women) | |
| Urology (Prostate-Urinary) | |
| Dermatology (Skin) | |
| ENT (Ear,Nose,Throat,Allergy) | |
| Surgeon | |
| Ophthalmology (Optometry-Eye Doctor) | |
| Podiatry (Foot) | |
| Other | |

WMC Health | Mahwah Medical
Bon Secours Medical Group
A Member of the Westchester Medical Center Health Network

10 Franklin Turnpike • Mahwah, NJ 07430
**Phone:** 201-529-0033 • **Fax:** 201-529-5913

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize (provider) _____ to disclose information/health records:

Patient name: _____ Date of Birth: _____

Address: _____ Phone: _____

Tests:

| | |
|---|---|
| | Mammogram<br>(Yearly for females age 40 & older) |
| | Dexa- Bone Density<br>(Every 2 yrs. for females 65 & older) |
| | Pap smear<br>(Women age 21-65 every 3 yrs or as indicated by your GYN) |
| | Eye Exam<br>(If you are Diabetic yearly dilated eye exam) |
| | COLONOSCOPY/COLOGUARD<br>(Due at age 50 & repeat every 10 years<br>Or as indicated by your GI) For Cologuard please speak to your physician) |

This information is to be disclosed to:

Doctor or Clinic: _____

Address: _____

Phone: _____ Fax: _____

For the purpose of: _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date or condition: _____

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

Signed (Patient): _____ Date: _____

Or legal representative: _____ Relationship to patient: _____