WMC Health Bon Secours Medical Group

Westchester Medical Center Health Network

Practice Communication and Personal Health Information (PHI) Form

By completing this form you will be granting Bon Secours Medical Group permission to release your Protected Health Information (PHI) to one or more personal representatives and/or to communicate with you in certain ways. Only the information indicated below will be released to your personal representative and/or communicated to you in the manner specified. This authorization is valid for one year from the date signed and will be renewed by the practice on a yearly basis. If at any time you would like to modify or revoke this permission you may do so by contacting the practice.

Patient Name: _____ Patient DOB: _____

Home Phone_____ Mobile Phone _____ Work Phone _____

Patient Address: _____

I request and authorize Bon Secours Medical Group to disclose and/or release my protected health information (PHI) to:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

This authorization applies to :(check all that apply)

___ Healthcare Information

___ Demographic Information

___ Mental Health Information

___ HIV Information

___ Alcohol/Drug Treatment Information

___ Financial Information

___ Other Information Please Specify

_____

_____

_____

I hereby authorize Bon Secours Medical Group to:

Leave a message on my [ ] home [ ] business [ ] cellular telephone answering machine/voicemail, this message may contain my protected health information (PHI).

I also authorized Bon Secours Medical Group to contact _____ at the following number _____ in case of an emergency or to contact me regarding urgent medical issues.

I have carefully read and understand the above authorization. This authorization applies to all medical offices within the Bon Secours Medical Group, unless otherwise specified. I also understand that this authorization may be revoked at any time by contacting the practice administrator.

Printed Patient Name: _____

Patient Signature: _____

Authorization Date: _____ Expiration Date: _____