Westchester Park Pediatrics

Affiliated with Boston Children's Health Physicians

MEDICAL RECORD REQUESTS

Medical record requests are considered a release of sensitive and private information. We have set forth a policy, which is strictly enforced to prevent and HIPPA violation of your child's personal information.

Below are the steps and information on how to request medical records from Westchester Park Pediatrics, affiliated with Boston Children's Health Physicians (BCHP)

1) You must fill out a BCHP medical record request form (see attached) for each child. Make sure that it has the child's name, date of birth and is signed by the parent/guardian. Please fill in all necessary information requested on the form. An incomplete form will result in a delay of preparing your child's medical records.
2) Once you have completed this form, return it to the front desk staff.
3) All requests will be processed within 10-28 business days. There are several steps that are to be taken before records are released.
    - There is a $0.75 cent charge per page printed. (Since records can be large in nature, the requestor has the option as to what information is needed, for example, the full chart or annual well visits only).
    - Once the record is complete, you will be contacted. You have the option to pick up the records or have them mailed to you. There is a five dollar ($5.00) charge for mailing the records. Only the requestor listed on the release form will be allowed to pick up any medical records.
    - Once you have requested your records to leave the practice, it is assumed that you will no longer receive medical care form Westchester Park Pediatrics and your chart will be placed in an "inactive status".

Although it may seem that our procedure is somewhat cumbersome, it is always done to protect the privacy of information we are sending out.

We appreciate your cooperation and patience while we process your request and protect your information.

Thank you for being part of the Westchester Park Pediatrics, an affiliation of Boston Children's Health Physicians (BCHP)

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing 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.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**