Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

865 Stone Street • Rahway, New Jersey 07065-2797 • (732) 381-4200

Authorization to Disclose Health Information

Patient Name: _____ **Date of Birth:** ____/____/____ **SS#**: _____
Address: _____

_____**Phone#:** _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type and amount of information to be used/disclosed/reviewed as follows: (include dates where appropriate)

- ❑ Inpatient ……... from (date) _____ to (date) _____
- ❑ Outpatient …… from (date) _____ to (date) _____
- ❑ Emergency Room ……..... from (date) _____ to (date) _____
- ❑ Laboratory results …… from (date) _____ to (date) _____
- ❑ X-ray imaging reports ……... from (date) _____ to (date) _____
- ❑ Entire record …… from (date) _____ to (date) _____
- ❑ Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to/used by/reviewed by the following individual or organization:

Name: _____

Address: _____

_____Phone#: _____

6. Purpose: (Please check one) Continuing medical care ____ Insurance application/claim ____ Attorney/legal issue____ Other ____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I 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. Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify an expiration date, event or condition, this authorization will expire in six months: _____

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer, at 732-499-6036. Please note, copy fee is $1.00 per page.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

***BY MAIL: Please complete this form and mail to: 865 Stone Street, Rahway, NJ 07065**
***IN PERSON: Bring completed form to - Medical Records Department-Lower Level**