01-1889

Robert Wood Johnson University Hospital | RWJBarnabas HEALTH

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last **First** **Middle**

Home Address: _____

_____

Home/Cell Telephone #: _____ **Date of Birth:** _____

Email Address (please print): _____

RECIPIENT: Name of Organization/Individual to whom the Hospital may disclose my health information including recipient's address, telephone and/or fax #, as applicable. *[Note: for pick-up by another individual (ID will need to be presented by the individual for verification.)]*

Recipient Name: _____

Recipient Address: _____

_____

Recipient Fax #: _____ **Recipient Telephone #:** _____

Date(s) of Treatment to be disclosed: _____

Type of information to be disclosed: (Check the appropriate boxes and include other information where indicated)
☐ Medical Abstract ☐ Demographics ☐ History & Physical ☐ Discharge Summary ☐ Complete Record ☐ Emergency Room Record
☐ Consultation(s) ☐ Operative Report(s) ☐ Lab Report(s) ☐ Radiology Report(s) ☐ Pathology Report(s) ☐ Other: _____
☐ If applicable: pictures, images, videos. Must specify procedure and date: _____

Purpose of Disclosure:
☐ Medical Care ☐ Insurance ☐ Personal ☐ Legal Matters ☐ Disability ☐ Other: _____

Delivery Options: ☐ **Paper** ☐ For Pick-up ☐ US Mail to above address
☐ **Electronic** *(format to be mutually agreed upon)* _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including A**LCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS** and **HIV, SEXUALLY TRANSMITTED, TUBERCULOSIS** and other **INFECTIOUS DISEASE** information, as applicable.

This authorization will automatically expire in 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: _____

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated. I understand that this disclosure of my health information, in accordance with the terms and conditions of this Authorization, also carries with it the potential for an unauthorized re-disclosure of my health information at which time my information may no longer be protected by federal and state confidentiality laws governing the use and disclosure of my health information.

In accordance with applicable law, disclosure of certain types of sensitive information of minors between the ages of 13 and 17 will not be disclosed without the minor's authorization.

I understand that I may at any time make a written request to the Health Information Department to inspect and/or obtain a copy of my health information as provided in CFR 164.524.

I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of treatment of me, enrollment in the health plan, or eligibility for benefits.

I understand that this Authorization will remain in effect until it expires as set forth above, or I provide a written notice of revocation to the attention of the Health Information Management Department (HIM) at the address listed above. The revocation will be effective i upon HIM's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Hospital in reliance on this Authorization before it received my written notice of revocation.

If I have questions about the disclosure of my health information, I can contact the Health Information Management Department at (732) 828-3000 Ext. 2590.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Hospital to use or disclose my health information in the manner described above.

_____ _____ _____
Signature of Patient **Date** **Signature of Witness or Employee**

If the patient does not have legal capacity or is otherwise unable to sign this Authorization, please sign and complete the information below:

_____
Signature of authorized Legal Guardian, Health Care Agent or other authorized Personal Representative
(Please attach documents supporting relationship as Legal Guardian, Health Care Agent or other authorized Personal Representative)

_____ _____ _____
Relationship **Date** **Witness**

FOR OFFICE USE ONLY: ID checked: ☐ YES ☐ NO ID Type: _____ Date Released: _____ Time: _____

Signature: _____ Printed Name: _____

Medical Record Request Fees: Medical records are provided at no cost when the records are requested to be sent to another healthcare provider for patient care. For all other requests, there is a charge to the patient/requestor.

01-1889 (6/21)

[provide a copy of signed Authorization to patient]

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