Trinitas Regional Medical Center | RWJBarnabas HEALTH

Mailing Addresses:
Williamson Street Campus
225 Williamson St., Elizabeth, NJ 07207

New Point Campus
655 E. Jersey St., Elizabeth, NJ 07206

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient: _____ **Date of Birth:** _____

Home Telephone: _____ **E-mail:** _____

Home Address: _____ _____**CD by Mail**

_____ _____**Paper Copy**

I authorize the use and disclosure of the above named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

_____

Specify information to be disclosed (check all that apply):

_____ H&P/Medical History	_____ Laboratory reports	_____ Medication History
_____ Psychiatric Evaluation	_____ Discharge Summary	_____ Diagnosis
_____ Psychosocial Assessment	_____ Contact Notes	_____ Treatment Plan

_____ **Other (specify):** _____

Type of Service	**DATES**
_____ Inpatient	_____
_____ Emergency Room	_____
_____ Clinic/Physical Therapy	_____
_____ Behavioral Health/Psychiatry	_____
_____ Other	_____

I understand that my medical record may also include information on diagnosis/treatment related to psychological or psychiatric condition(s), alcohol and/or drug abuse, generic information, acquired immune deficiency syndrome (AIDS), and/or HIV status. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

I do _____ do not_____authorize this information to be released.

(You must initial one)

This information has been disclosed from records protected by Federal confidentiality rules (42CFR Part II) and NJ State Rules. The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II.

Records to be released to: _____

Address: _____

List the purposes: _____

I understand that I may refuse to sign or may revoke this authorization for any reason at any time and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Trinitas Regional Medical Center. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services 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 month.

I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

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. By my signature below, I hereby, knowingly and voluntarily, authorize Trinitas Regional Medical Center to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient or Legal Representative **Date/Time** **If Signed by Legal Representative, Relationship to Patient**