Monmouth Medical Center
Monmouth Medical Center Southern Campus

RWJBarnabas HEALTH

Jacqueline M. Wilentz Breast Imaging Services
300 Second Ave. Long Branch, NJ 07740
JWBC Centralized Scheduling 732-923-7700
Fax (JWBC Film Library) 732-923-7715

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
PLEASE FAX COMPLETED FORM AND PRESCRIPTION

☐ Change Facility ☐ Film Review Consultation

Patient Name:_____ D.O.B.:_____

Address:_____

Phone Number:_____ Referring Physician_____

I hereby authorize Monmouth Medical Center to obtain my health information, Including all CDs and reports, from:

Previous Imaging Facility:_____

Address:_____

Phone Number:_____

Fax Number:_____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

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 above.

I understand that I have the right to revoke this authorization at any time. I understand 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 this revocation will not apply to the extent that Monmouth Medical Center has already taken action in reliance on this authorization. I understand the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. This authorization will automatically expire 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: _____.

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, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of 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 un-authorized re-disclosure 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 Health Information Management Department at (732) 923-7400**.**

PATIENT SIGNATURE: _____ DATE:_____
If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE:_____ DATE:_____

RELATIONSHIP:_____

WITNESS:_____ DATE:_____