Robert Wood Johnson | RWJBarnabas University Hospital Hamilton

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name:		First		181.1.1.	
***************************************	-			Middle	
Home Address:					
Home/Cell Telephone #:			Date of Birth:		
Email address (pleas	e print):			_	
address, telephone an	d/or fax #, as applicable	I to whom the Hospital may e. iil need to be presented by		rmation including recipient's ation.)	
Recipient Name:					
Recipient Address:					
Recipient Fax #:		Recipient	Telephone #		
Treatment to be disci	osed:				
Type of information t ☐ Medical Abstract 0 Room Record	o be disclosed: (Chec □ Demographics □ H	k the appropriate boxes and listory & Physical ☐ Disch	d include other informat narge Summary ☐ Corr	ion where indicated) nplete Record □ Emergency	
□ Consultation(s) □ C)perative Report(s) ☐ L es, images, videos. Mu	ab Report(s) Radiology st specify procedure and defined and defi	y Report(s) 🗆 Pathology ate:	y Report	
Purpose of Disclosur	e:				
Delivery options:	☐ Paper ☐ F	For Pick-up □ US Ma mat to be mutually agreed t	il to above address		
DRUGS, GENETIC TE	STING, BEHAVIORAL	ed includes my identity, dia OR MENTAL HEALTH SE JLOSIS and other INFECTI	ERVICES. REPRODUC	TIVE RIGHTS, AIDS and	
This authorization wil authorization will term	ll automatically expire ninate on the followin	in 120 days from the date g date, or concurrently wit	of my signature, unle th the following event	ss I otherwise specify that this or condition:	
It is my intent that the u	use of the information fu	urnished is prohibited for an	y purpose other than st	ated 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 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 609-584-6620.

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 the 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)					
For Office Use Only:					
ID checked: YES or 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.

One Hamilton Health Place • Hamilton • New Jersey • 08690-3599 • Health Information Management Department • Telephone #: 609-584-6620 • Fax #: 609-584-6692