Hunterdon Health

Authorization for Disclosure of Protected Health Information

I, _____hereby authorize _____
to disclose information from the records of:

_____ ____/_____/_____
Patient's Name **Date of Birth**

_____
Patients Address **City** **State** **Zip Code**

Released From:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone**: _____

Release to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

How should records be sent? ☐Mail to address above ☐Send to the patient portal ☐Pickup at the office
☐Fax to facility: _____ ☐Email: _____

Purpose for request:
_____**For personal use only** (not transferring from practice)
_____**Transferring care to another local practice due to**_____
_____**Relocation out of area**
_____**Other**
_____**Insurance change-related (please indicate carrier**_____

The following information is to be released: (Please check one)

_____**Entire Medical Record**. Records specifically protected under State and Federal Confidentiality Statues. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and Federal law and prohibits any further disclosure without written consent of the persons to whom it pertains or otherwise provided by law.

_____**Only specific portions of the medical record**. Itemize portions of record and time period of records to be released and indicate specific records that may not be released.

Date Range: from _____/_____/_____ to: _____/ _____/ _____

Check the records that you would like released: ☐Lab results ☐EKG result ☐Office visit note ☐Radiology reports
☐Colonoscopy Report ☐Pathology Report ☐Itemized Bill ☐Other: _____

Specific records **NOT** to be released: _____

THIS AUTHORIZATION WILL REMAIN IN EFFECT: (Check One):

□ Until the following event occurs: _____ □ 180 Days □ OTHER: _____

Hunterdon Health

Patient's Name:_____ DOB_____

I understand that once Hunterdon Health discloses my health information to the recipient, Hunterdon Health cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Hunterdon Health may, directly or indirectly, receive remuneration from a third part in connection with the use or disclosure of my health information.

I understand 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 my treatment at Hunterdon Health; except, however, if my treatment in the Hunterdon Health is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Hunterdon Health may refuse to treat me if I do not sign this Authorization.

If my treatment is related to my participation in a research study, I understand that treatment may be refused if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Hunterdon Health Privacy Officer at the address listed below. The revocation will be effective immediately upon Hunterdon Health receipt of my written notice, except that the revocation will not have any effect on any action taken by Hunterdon Health in reliance on this Authorization before it received my written notice of revocation.

I may contact Hunterdon Health by mail at:

Hunterdon Health
Health Information Management Services
2100 Wescott Drive
Flemington, N.J. 08822
Phone: 908-788-6380

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 the Hunterdon Health to use or disclose my heath information in the manner described above.

_____ _____
Signature of Patient/Parent/Legal Guardian **Date**

_____
Relationship to Patient

Notice to Recipient of Information

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials under Part 3 of this form, the following Notice applies to the information you have received pursuant to this information. This information has been disclosed to you from records protected by Federal confidentiality rules C.F.R. Part @. The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.