

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_

Address (number and street) \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby authorize and request EHMC to  Release information to  Obtain information from

Name/Facility \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

FOR THE PURPOSE OF: \_\_\_\_\_

**INFORMATION TO BE RELEASED/OBTAINED**

(Please check appropriate type(s) of visit(s) and specify visit date(s))

INPATIENT: (Please specify below)

Abstract (includes discharge summary, history and physical, consults, operative reports, clinical information as appropriate)

Date(s) \_\_\_\_\_

Complete Record Date(s) \_\_\_\_\_

EMERGENCY DEPARTMENT

Emergency Department Date(s) \_\_\_\_\_

SAME DAY SURGERY

Same Day Surgery Date(s) \_\_\_\_\_

OUTPATIENT

Outpatient Date(s) \_\_\_\_\_

Specify Departments  Lab  Breast Center  Physical Therapy

Radiology  Cardiology  Other (Specify): \_\_\_\_\_

**FORMAT OF INFORMATION TO BE RELEASED:**  Paper Copy  Electronic Copy (CD)

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

\_\_\_\_\_ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection

\_\_\_\_\_ Psychiatric Care \_\_\_\_\_ Genetic Information

\_\_\_\_\_ Treatment for alcohol and/or drug abuse \_\_\_\_\_ Sexually Transmitted Disease(s)

\_\_\_\_\_ Tuberculosis

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expire on \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days. (Insert date or event)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that I will be given a copy of this form after I sign it.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
If signed by Legal Representative, Relationship to Patient

**NOTICE TO RECIPIENT OF INFORMATION**

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (41 CFR Part 2) prohibits you from making further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR, 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.



ROI

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Upon receipt of proper request in writing, all requests will be processed in accordance with  
N.J.A.C. 8:43G-15.3**

**FEE SCHEDULE FOR PATIENT REQUEST:** \$0.36 per page plus postage and handling

**FEE SCHEDULE FOR OTHER REQUESTS:** \$10.00 processing and labor fee  
\$1.00 per page for the first 100 pages  
\$0.25 per page for remaining pages but not to exceed \$200.00 per admission

**RADIOLOGY FEE:** \$5.00 per 10x17 copy

**FEE SCHEDULE ABOVE IS NOT APPLICABLE FOR THE FOLLOWING:**

**1. Records mailed directly to a Physician/Health Care Facility**

The facility will mail copies of requested records directly to a Physician/Health Care Facility at no charge to the patient.

**2. Medical Emergency Case (records needed for medical care within 48hrs or less)**

Written consent by Patient/Patient Representative is required.

Arrangement will be made for a scheduled pickup or records may be faxed per direct request from treating physician. The physician's name, address, phone number, fax number (if applicable), and appointment time is mandatory for above transaction.

**FOR DEPARTMENT USE ONLY**

If the patient is a minor, a parent, next of kin or legal guardian must sign the authorization with the following exceptions and as prohibited by law:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> The minor is pregnant.                                 | <input type="checkbox"/> The minor is married.                           | <input type="checkbox"/> The minor is emancipated.<br>(court determined) |
| <input type="checkbox"/> The treatment is a state funded mental health service. | <input type="checkbox"/> The treatment is for Drug and/or Alcohol Abuse. |  |
| <input type="checkbox"/> The treatment is for a Sexually Transmitted Disease.   | <input type="checkbox"/> The treatment is for AIDS or HIV.               |  |

**IDENTIFICATION VERIFIED VIA:**

- Drivers License                       Other \_\_\_\_\_

**IF COPIES ARE HAND CARRIED, OBTAIN SIGNATURE BELOW:**

Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_