ENGLEWOOD HEALTH

350 Engle Street
Englewood, NJ 07631
Attention: Health Information Management
Phone (201) 894-3170
Fax (201) 608-2477

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) ❑ MyChart

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
_____ Behavioral Health
_____ 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 CRF 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

ENGLEWOOD HEALTH

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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: $0.90 flat fee + $0.05 per page + postage

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:

❑ The minor is pregnant. ❑ The minor is married. ❑ The minor is emancipated. (court determined)

❑ The treatment is a state funded mental health service. ❑ The treatment is for Drug and/or Alcohol Abuse.

❑ The treatment is for a Sexually Transmitted Disease. ❑ The treatment is for AIDS or HIV.

IDENTIFICATION VERIFIED VIA:

❑ Drivers License ❑ Other _____

IF COPIES ARE HAND CARRIED, OBTAIN SIGNATURE BELOW:

Signature: _____ Date/Time: _____