350 Engle Street
Englewood, NJ 07631

ENGLEWOOD HEALTH

AUTHORIZATION FOR RELEASE OF INFORMATION

Attention: *Health Information Management*
Phone (201) 894-3170
Fax (201) 608-2477

For imaging requests only, send form by email to: imagerequest@ehmchealth.org

PATIENT INFORMATION:

Name:_____ Date of Birth: _____

Street Address: _____

City, State, ZIP:_____ Telephone:_____

Email Address:_____

I authorize and request Englewood Health to: ☐ release information to myself
☐ release information to the name/facility below
☐ obtain information from the name/facility below

Facility: _____ Attention to:_____

Street Address: _____

City, State, ZIP:_____ Telephone:_____

Email Address:_____ Fax:_____

INFORMATION TO BE RELEASED/OBTAINED:

☐ INPATIENT ABSTRACT (includes discharge summary, history and physical, consults, operative reports, clinical information as appropriate) FOR DATE(S): _____

☐ INPATIENT COMPLETE RECORD FOR DATE(S): _____

☐ OUTPATIENT RECORD FOR DATE(S): _____

Please specify which outpatient department(s):

☐ Emergency Dept ☐ Same-Day Surgery ☐ Lab ☐ Imaging/Radiology ☐ Breast Center
☐ Cardiology ☐ Physical Therapy ☐ Other: _____

SENSITIVE INFORMATION:

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

Please initial if requested:

_____ HIV/AIDS _____ Behavioral Health (Psychiatry) _____ Genetic Information
_____ Tuberculosis _____ Alcohol/drug use _____ Sexually transmitted infections

FORMAT OF INFORMATION:

☐ Paper ☐ MyChart ☐ CD delivered to above address ☐ CD pickup at Englewood / Emerson / Fair Lawn (circle location)
☐ Email (radiology/imaging/breast center results only)

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.

X_____ X _____
Signature of Patient or Legal Representative *Date/Time*

X_____
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.

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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

NO FEE FOR PATIENT REQUEST FOR MEDICAL RECORDS OR IMAGING STUDIES VIA EMAIL

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
$30 per CD for Radiology Requests, plus $10 processing and labor fee

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: _____