Hackensack Meridian *Health*

AUTHORIZATION TO USE OR DISCLOSURE PROTECTED HEALTH INFORMATION

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RI0000

PATIENT LABEL

Patient Name	Date of Birth	Medical Record #	Contact Number
Address (Street, City, State, Zip Code)			

Location of Services:

☐ Bayshore Medical Center	☐ Hackensack UMC	☐ Jersey Shore University Medical Center	☐ Palisades Medical Center
☐ Ocean Medical Center	☐ Raritan Bay Medical Center ☐ Old Bridge ☐ Perth Amboy	☐ Riverview Medical Center	☐ Southern Ocean Medical Center
☐ Other HMH Facility: (please specify)			

I hereby authorize Hackensack Meridian Health (HMH) to use and disclose the protected health information described below to _____ (individual seeking the information).

I authorize Hackensack Meridian Health to obtain records from:

_____

_____

Information to be provided to:

Name of Person or Institution:	Telephone Number:
Address (Street, City, State, Zip Code):	
Purpose/Use of the Requested Information: ☐ Personal use by patient ☐ Sharing with other health care provider(s) ☐ Other: (please describe)	
Format: ☐ Paper Copy ☐ Electronic Copy (if available provided on encrypted disk or USB) ☐ Secured E-mail ☐ Electronic delivery (CIOX)	
Treatment Dates: (specify)	

Special Reports:

☐ Abstract (Face Sheet, Discharge Summary, H&P, ED, Consults, OP Report, Pathology, Lab and Diagnostic Studies)			
☐ Cardiology Report	☐ Emergency Dept. Record	☐ Mental Health Consult/Evaluation	☐ Physical Therapy/OCC Therapy
☐ Complete Medical Record	☐ Immunization Record	☐ Oncology Records	☐ Radiology Films
☐ Consultation Report	☐ Laboratory Report	☐ Operative Report	☐ Radiology Reports
☐ Discharge Summary	☐ Medication Sheet	☐ Pathology Reports	☐ Radiation Therapy
		☐ Pathology Slides/Specimens (See Appendix B)	☐ Other (specify)

Hackensack Meridian *Health* Hospitals Corp.

AUTHORIZATION TO USE OR DISCLOSURE PROTECTED HEALTH INFORMATION

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RI0000

PATIENT LABEL

Sensitive Information: 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

_____ Communicable Disease(s) _____ Sexually Transmitted Disease(s) _____ Genetic information

_____ Psychiatric Care _____ Treatment for alcohol and/or drug abuse

Please Initial:

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_____(Insert date or event). If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative_____Date _____ Time_____am/pm

If signed by Legally Authorized Representative, Relationship to Patient _____

Signature of Witness_____Date _____ Time_____am/pm

Identification Verified Via:

☐ Driver's License ☐ Government Issued ID ☐ Verified By:_____

If copies of medical records are handcarried, obtained signature below

Signature_____Date _____ Time_____am/pm

NOTICE TO RECIPIENT OF INFORMATION

PROHIBITION ON RE-DISCLOSURE: 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 (42 CRF Part 2) prohibits you from making further disclosure of this information unless 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.

- **ALL REQUESTS WILL BE PROCESSED IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS**
- Applicable copying fees may be applied, please contact respective site Health Information Department

Bayshore Medical Center	732-739-5985
Hackensack UMC	551-996-2342
Jersey Shore University Medical Center	732-776-4771
Palisades Medical Center	201-354-5081
Ocean Medical Center	732-840-3331
Raritan Bay Medical Center Old Bridge	732-360-4237
Raritan Bay Medical Center Perth Amboy	732-324-5391
Riverview Medical Center	732-530-2510
Southern Ocean Medical Center	609-978-3820