Authorization For Release Of Information

* A U T H 3 3 *

Parents must complete this form in order to receive patient information.

PATIENT NAME: _____ **LOCATION:** _____

DATE OF BIRTH: _____ **Date of Service:** _____

1. I, the undersigned, being the patient/parent/legal guardian, do authorize **Children's Specialized Hospital** to release the patient's Protected Health Information of the above listed patient for this/these encounter(s).

2. The information to be disclosed and used as follows (provide dates as appropriate):

- ☐ Evaluation: (specify)_____
- ☐ Therapy Progress Notes
- ☐ Progress Summary
- ☐ Therapy Discharge Summary
- ☐ Other:_____
- ☐ Consultation Report
- ☐ Physician Progress Notes
- ☐ Inpatient Only
- ☐ Medical Discharge Summary
- ☐ Transdisciplinary Summary
- ☐ Entire Medical Record

3. I understand that the information may contain **HIV/AIDS, Psychiatry, Psychology Information, Sexually Transmitted Disease, Tuberculosis, Genetic information.** I authorize the information to be disclosed to and used by the following organization or individual:

Name: _____

Address, City, State, Zip: _____

Phone #:_____ Fax #: _____

4. For the purpose of: _____

5. I understand that I have the right to revoke this authorization at any time and that it must be done in writing. I understand that this revocation does not apply to information that has already been released. I understand that this revocation does not apply to my Insurance Company(s) request when the law allows my insurer rights to access information under my policy. I understand that authorizing to release information is voluntary and that refusal to sign will not affect treatment. This authorization will expire on the following date:_____ If I do not specify a date of expiration, this authorization will expire in one year from signing.

6. I understand that I may review the information and/or retain a copy of the information to be disclosed, as listed under 45CFR 164.524. I understand that any disclosure of information has the potential for an unauthorized disclosure and that the information may not be protected by Federal and State Confidentiality Rules. I understand that if I have any questions about disclosure of my health information, that I may contact the Director, Health Information Management Services Department. I understand that under certain circumstances such as Foster Parent, Resource Parent, Custody, etc., that I will be required to produce, specific current/valid legal documents.

_____ _____

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

_____ _____

Signature of Minor (14 years or age or older if psychiatry and/or psychology information released) **Date**

_____

Relationship to Patient

Notice to the recipient of this information: This information has been disclosed to you from medical records whose confidentiality is protected by Federal and State Regulations. Federal and State Regulation prohibit you from re-disclosure without the written consent of the patient, parent, or legal guardian or otherwise permitted by specific regulations. Anyone who receives this information covered by these regulations obtained legally or not, is prohibited by law from using the information for any criminal or civil investigation. (Federal Regulation 42 CFR Part 2) (N.J.S.A.)