Jersey City Medical Center | RWJBarnabas HEALTH

355 Grand Street, Jersey City, NJ 07302

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last **First** **Middle**

Home Address: _____

_____

Home/Cell Telephone #: _____ _____ **Date of Birth:** _____

Email address (please print): _____ **Patient Fax#:**_____

RECIPIENT: Name of Organization/Individual to whom RWJBH may disclose my health information including address, telephone and/or fax #, as applicable.
(*Note: for pick-up by another individual (id will need to be presented by the individual for verification.)*

Recipient Name:_____

Recipient Address: _____

_____

Recipient Fax #: _____ **Recipient Telephone #:**_____

Date(s) of Treatment to be disclosed:

_____
_____ _____

Type of information to be disclosed:
COVID-19 Results

Purpose of Disclosure:
COVID-19_____

Delivery options: ❑ **Paper** ❑ US Mail to above address
❑ **Electronic (choose one)** ❑ **Secure email** ____ ❑ **Fax** ❑ **CD via US mail** _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including **ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS** and **HIV, SEXUALLY TRANSMITTED, TUBERCULOSIS** and other **INFECTIOUS DISEASE** information, as applicable.

This authorization will automatically expire in 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:_____.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated. I understand that this disclosure of my health information, in accordance with the terms and conditions of this Authorization, also carries with it the potential for an unauthorized re-disclosure of my health information to a third party and may not be protected by federal and state confidentiality laws governing the use and disclosure of my health information.

In accordance with NJ regulation, minors between the ages of 13 and 17 may be required to sign this authorization under certain situations, including but not limited to: the minor is pregnant, the minor is legally married, the minor is emancipated (court documentation required) or the minor is seeking treatment for mental health, STD, suspected or confirmed HIV/Aids or treatment related to alcohol or drugs.

I understand that I may at any time make a written request to the Health Information Department to inspect and/or obtain a copy of my health information as provided in CFR 164.524. Within thirty (30) days of receiving such written request, the facility will either grant the request and contact me to arrange for a convenient time to inspect and/or receive a copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of treatment of me, enrollment in the health plan, or eligibility for benefits.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the attention of the Health Information Management Department at the address listed above. The revocation will be effective immediately upon RWJBH's receipt of my written notice, except that the revocation will not have any effect on any action taken by RWJBH in reliance on this Authorization before it received my written notice of revocation.

If I have questions about the disclosure of my health information, I can contact the Health Information Management Department at 201-915-2151.

I may also contact with any privacy concerns:
Privacy Officer / Jersey City Medical Center / 355 Grand Street / Jersey City, New Jersey 07302
Phone: (201) 984-1266

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize RWJBH to use or disclose my health information in the manner described above.

_____ _____ _____

Signature of the Patient **Date** **Signature of Witness or Employee**

If the patient is a minor (17 years old or younger excluding the age 13-17 exceptions above) or the patient is otherwise unable to sign this Authorization, please sign and complete the information below:

_____

Signature of authorized Legal Guardian, Health Care Agent or other authorized Personal Representative
(Please attach documents supporting relationship as Legal Guardian, Health Care Agent or other authorized Personal Representative)

_____ _____ _____

Relationship **Date** **Witness**

For Office Use Only:

ID checked: YES or NO ID type:_____

Date Released:_____ Time:_____

Signature:_____ Printed Name:_____

To submit this form to HIM: (You must also include a form of identification when submitting.)

1. Fax to 201-915-2559 or 201-915-2556
2. Call 201-915-2151 to obtain an email address.
3. Send via mail.
4. Drop off at Information Desk in hospital main lobby.

[provide a copy of signed Authorization to patient]