MR#: ____________________

Patient Name: ____________________ Date of Birth: ____________________

Address: ____________________

City/State/Zip: ____________________Telephone Number: ____________________

I hereby authorize **Monmouth Medical Center** – **Southern Campus** of Lakewood, New Jersey to disclose my health information to: ____________________

____

____

The information to be disclosed to and used by the above is for the following purpose:

□ **CONTINUING CARE** □ **ATTORNEY / LEGAL** □ **INSURANCE** □ **OTHER:** ____________________

This authorization is limited to the following dates of treatment: **FROM:** ____________ **TO:** ____________

Information is to be faxed to the receiver: **YES** ☐ **FAX #:** ____________ **NO** ☐

Information to be disclosed:

□	FACESHEET	□	DISCHARGE SUMMARY	□	HISTORY & PHYSICAL EXAM
□	CONSULTATIONS	□	LABORATORY & X-RAYS	□	OPERATIVE REPORTS AND PATHOLOGY
□	PROGRESS NOTES	□	DOCTOR'S ORDERS	□	EMERGENCY ROOM REPORT
□	NURSE'S NOTES	□	COMPLETE RECORD	□	ADMISION ASSESSMENT
□	PSYCHOSOCIAL	□	MEDICATIONS	□	ABSTRACT OR OTHER:

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.

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 above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to the extent that **Monmouth Medical Center – Southern Campus** has already taken action in reliance on this authorization. This authorization will automatically expire **120** days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following day or concurrently with the following event or condition:

____

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, payment or enrollment or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the correspondence department at 732-363-1900 extension 22181.

DATE: ____________________ PATIENT SIGNATURE: ____________________

WITNESS: ____________________ LEGAL REPRESENTATIVE: ____________________

WITNESS: ____________________ CIRCLE ONE: PARENT / LEGAL GUARDIAN / POA / HEALTH CARE PROXY

(Two witnesses required for Verbal Consent)

ATTACH THE DOCUMENT OF AUTHORITY

(For Office Use Only)

Date information released: ____________________ **Signature**: ____________________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Identification