

201 Lyons Avenue Newark, New Jersey 07112

<u>AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION</u>

Patient's Name:				
Last		First	Middle	
Home Address:				
	City	State	ZIP code	
Home/Cell Telephone #:		Date of Birth:	_	
Email address (please print):				
telephone and/or fax #, as applicable	e.	ospital may disclose my health infornesented by the individual for verificat	nation including recipient's address,	
Recipient Name:				
Recipient Address:				
	City		ZIP code	
Recipient Fax #:	•	Recipient Telephone#:		
Date(s) of Treatment to be disclos	sed:			
Type of information to be disclose ☐ Medical Abstract ☐ Demogr ☐ Emergency Room Record		e boxes and include other information Physical Discharge Summa	ŕ	
□ Consultation(s)□ Operative I□ If applicable: pictures, images, v	1 ()	,	athology Report Other:	
Purpose of Disclosure: ☐ Medical Care ☐ Insurance	□Personal □	Legal Matters Disability	☐ Other:	
Delivery options: ☐ Paper☐ Electronic	☐ For Pick-up ☐ (format to be mutually agi	US Mail to above address reed upon)		
	TAL HEALTH SERVICES	S, REPRODUCTIVE RIGHTS, AIDS	cluding ALCOHOL, DRUGS, GENETIC and HIV, SEXUALLY TRANSMITTED,	
		om the date of my signature, unles urrently with the following event o		

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 at which time my information may no longer be protected by federal and state confidentiality laws governing the use and disclosure of my health information.

In accordance with applicable law, disclosure of certain types of sensitive information of minors between the ages of 13 and 17 will not be disclosed without the minor's authorization.

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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.

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 it expires as set forth above, or I provide a written notice of revocation to the attention of the Health Information Management Department (HIM) at the address listed above. The revocation will be effective upon HIM's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Hospital in reliance on this Authorization before it received my written notice of revocation.

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

If I have questions about the disclosure of my health information, I can contact the Health Information Management Department at 973-926-7409.

my health information. I hereby, knowingly and voluntarily, authorize the Hospital 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 does not have legal capacity or 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) Date Witness Relationship For Office Use Only: ID checked: YES or NO ID type: ___ Time: ___ _am/pm Date Released: __ Signature: ___ Printed Name:

Medical Record Request Fees:

Medical records are provided at no cost when the records are requested to be sent to another healthcare provider for patient care. For all other requests, there is a charge to the patient/requestor.

(Provide a copy of signed Authorization to patient]