Robert Wood Johnson University Hospital | **RWJBarnabas HEALTH**

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: ____
Last   First   Middle

Home Address: ____

____

Home Telephone: ______________________ **Date of Birth:** ______________________

RECIPIENT: Name of organization to whom RWJUH may disclose my health information: ______________________

Address of Recipient or where my health information should be delivered: ______________________

____

Fax Number: ______________________ **Telephone Number:** ______________________

Dates of Treatment: ______________________

Type of information to be disclosed: (Check the appropriate boxes and include other information where indicated)
☐ Medical Abstract ☐ Demographics ☐ History & Physical ☐ Discharge Summary ☐ Entire
☐ Consultation(s) ☐ Operative Report(s) ☐ Lab Report(s) ☐ Radiology Report(s) ☐ Radiology Image(s) ☐ Other: __________

Purpose of Disclosure:
☐ Medical Care ☐ Insurance ☐ Personal ☐ Legal Matters ☐ Other: ______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, genetic information, and treatment for alcohol and drug abuse.

TERM: This Authorization will remain in effect:

☐ Until I revoke it in writing

☐ From the date of this Authorization until the __________ day of ______________________, 20 _______

☐ Until the following event occurs: ______________________

☐ Until the following condition is met: ______________________

If I fail to specify an expiration event or condition, this authorization will expire in six months.

I understand that once RWJUH discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, RWJUH cannot guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may at any time make a written request to RWJUH to inspect and/or obtain a copy of my health information, and that RWJUH will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or 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 RWJUH may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand 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 RWJUH's 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 RWJUH's Privacy Officer at the address listed below. The revocation will be effective immediately upon RWJUH's receipt of my written notice, except that the revocation will not have any effect on any action taken by RWJUH in reliance on this Authorization before it received my written notice of revocation.

RWJUH's Privacy Officer may be contacted at the following address, telephone number or e-mail address:
Privacy Officer / Robert Wood Johnson University Hospital / 1 Robert Wood Johnson Place / New Brunswick, New Jersey 08901
Phone: (732) 828-3000 ext. 5463

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 RWJUH to use or disclose my health information in the manner described above.

______________________ ______________ ______________________
Signature of Patient **Date** **Signature of Witness or Employee**

If the patient is a minor or is otherwise unable to sign this Authorization, please complete the information below:

____
Signature of authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative

______________________ ______________ ______________________
Relationship Date Witness

[provide a copy of signed Authorization to patient]