Atlantic Health System

DT2201

MRN/HAR: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Request ID: _____

SECTION A: **Patient Information:** Daytime Phone Number: _____

Patient Name: _____ Date of Birth: _____

Patient's Address: _____

I hereby authorize and request Atlantic Health System to release information related to treatment at (check one):

☐ Morristown Medical Center ☐ Overlook Medical Center ☐ Newton Medical Center ☐ Chilton Medical Center

☐ Hackettstown Medical Center ☐ Pharmacy ☐ Atlantic Medical Group (specify): _____

☐ Atlantic Visiting Nurse ☐ Other (specify): _____

Information to be released to (receiver): ☐ Check if the same as patient

Recipient Name/Facility/Organization: _____

Complete Address: _____

Phone Number: _____ Attention to: _____

Purpose of Release: ☐ Physician ☐ Facility ☐ Personal Use ☐ Legal ☐ Other: _____

Request Delivery Type *(if blank, a paper copy will be provided)*: ☐ Paper Copy ☐ Electronic Media (CD) ☐ MyChart

☐ Encrypted Email*: _____ ☐ Fax Number: _____ ☐ Pick-Up

In the event the facility is unable to accommodate an electronic delivery as requested, an alternate delivery will be provided (e.g. paper). ☐ Postal Mail

***NOTE:** Choosing encrypted email delivery involves some level of risk. We are not responsible for unauthorized access to the PHI contained in this format, or any risks (e.g. virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.*

SECTION B: ☐ **I hereby authorize Atlantic Health System to obtain medical records from:**

Name: _____ Fax Number: _____

Address: _____ Dates of Service: _____

SECTION C: **Description of Information to be Released/Obtained:** **Dates of Service:** _____

☐ Abstract (most common) face sheet, discharge summary, history & physical, consult, test results, operative reports, ED

☐ Admission/Face Sheet	☐ EEG/Sleep Reports	☐ Mental Health Consult/Eval	☐ _____
☐ Complete Medical Record	☐ History & Physical	☐ Operative Report	☐ _____
☐ Consultation Report	☐ Immunization Record	☐ Pathology Report	☐ _____
☐ Discharge Summary	☐ Laboratory Report	☐ Pathology Slides/Specimen	
☐ Cardiology/Radiology Images	☐ Medication Record	☐ Radiology Report	

Special Instructions: _____

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

_____ HIV/AIDS Treatment Records _____ Psychiatric Treatment Records _____ Genetic Testing/Treatment Records

_____ Treatment for Alcohol and/or Drug Abuse _____ Sexually Transmitted Diseases Testing _____ Reproductive Healthcare Services

SECTION D: **Patient Authorization: I understand that:**

1. Unless revoked by me, this authorization is valid for 6 months from the date above. Revocations must be made in writing. Mail revocation to any of our locations on the back of this form. Revocation may not be made if action has already been taken in reliance on this authorization.
2. I understand the terms of this authorization are governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, it may be amended from time to time.
3. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits.
4. Atlantic Health System cannot guarantee that the recipient identified will not re-disclose my health information to a third party.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.

Patient/Authorized Representative or Guardian: _____ Date: _____ Time: _____

(signature of minor at age or above 12 is required for certain information)

If signed by legal authorized representative, specify relationship: _____

Atlantic Health System Personnel Signature: _____ Date: _____ Time: _____

DIRECTIONS FOR COMPLETING THE AUTHORIZATION TO RELEASE INFORMATION
*NOTE: Release of Information will occur after hospital discharge

HIPAA regulations allow a healthcare entity up to 30 days to process copy requests for medical records. We generally complete requests prior to the allotted time permitted, but due to the possibility for a heavy volume of requests received, we cannot guarantee a specific date prior to the 30 days.

SECTION A:
- Fill in today's date.
- Provide the patient's name, date of birth, medical record number if known, patient address and daytime phone number.
- Select the Atlantic Health System hospital or physician practice where you were treated.
- Provide the name and address of the recipient. The recipient is whoever is going to receive the records. If the recipient's name is the same as the patient, check the box and move onto the next section.
- Identify the purpose (reason) you are requesting copies of medical records by checking the appropriate box.
- Next, check the method of delivery: paper copy, electronic copy (CD), fax, encrypted email, MyChart.
- If by mail, provide the email address clearly and legibility and read the risk notice under Request Delivery Type section.
- If by fax, be sure to write in the correct fax number legibly, including area code.

SECTION B:
- If an Atlantic Health System facility or physician has asked that they obtain your medical records from another facility, check this box and fill out the facility, physician or organization name and complete address.
- Please indicate the dates of service. If you do not know the exact dates, please enter the year.

SECTION C:
- Indicate what information you are requesting. Most common is the Abstract, which contains the face sheet, discharge summary, history and physical, ER report, consultation, all tests such as lab, radiology, and operative reports from physicians.
- Otherwise, check the box identifying the information you need or write in the specific information you need.
- Place your initials next to HIV/AIDS, Drug/Alcohol, Genetic, Sexual Disease, or Psychiatric, if you would like this sensitive information released as part of your medical record. This requires additional acknowledgment by the patient or their legal authorized representative.

SECTION D:
- The patient must sign and date the form.
- If the patient has a legally authorized representative, please sign and date the form. A spouse is not a legal representative unless they have legal power of attorney or healthcare surrogacy paperwork. A copy of the legal paperwork must be submitted with this request.
- Patients over the age of 18 years of age must request their own records, unless otherwise legally unable to sign this authorization. If legally unable to sign,documentation must be provided such as guardianship paperwork or healthcare proxy.
- Minor patients have the right to consent to care and therefore, the minor patient may also control the release of their medical record information related to their treatment. Minors age 12-17 must authorize the release of certain information concerning the minor such as HIV/AIDS, Drug Alcohol, Psychiatric, Sexual Disease, Pregnancy and Abortion Services.

If the hospital determines that your records or information are protected by federal or state law concerning confidentiality of alcohol or drug abuse records, diagnosis and treatment of HIV/AIDS or HIV related illness, the following note will be attached to the release: *"NOTE to Recipient of Information: This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CFR part 2; N.J.S.A. 26:5C-1 et. seq.) The Federal or State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2 or N.J.S.A. 25:5C-1 et. seq. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal or State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."* This authorization shall not be used to disclose protected health information for marketing purposes and/or the sale of protected health information.

Atlantic Health System Locations and Contact Information
All Major Holidays Observed

Chilton Medical Center
97 West Parkway · Pompton Plains, NJ 07444
phone: 973.831.5051 fax: 973.831.5257
email: cmc.him@atlantichealth.org
Hours of Operation: Monday-Friday 9am-6pm

Hackettstown Medical Center
651 Willow Grove Street · Hackettstown, NJ 07840
phone: 908.850.7745 fax: 908.441.1180
email: hmcmedicalrecords@atlantichealth.org
Hours of Operation: Monday-Friday 8am-4pm

Morristown Medical Center
100 Madison Avenue · Morristown, NJ 07960
phone: 973.971.5183 fax: 973.290.7999
email: mmhmedrec@atlantichealth.org
Hours of Operation: Monday-Friday 8am-6pm;
Saturday & Sunday 8am-4pm

Newton Medical Center
175 High Street · Newton, NJ 07860
phone: 973.579.8365 fax: 973.383.4559
email: nmcmedicalrecords@atlantichealth.org
Hours of Operation: Monday-Friday 8am-4pm

Overlook Medical Center
99 Beauvoir Avenue · Summit, NJ 07901
phone: 908.522.2111 fax: 908.273.1272
email: ohhealthrecords@atlantichealth.org
Hours of Operation: Monday-Friday 8am-5pm

Atlantic Health System - Release of Information
100 Southgate Parkway · Morristown, NJ 07960
phone: 973.630.1725 fax: 973.630.1726
email: atlantichealthROI@atlantichealth.org
Hours of Operation: Monday-Friday 8am-4:30pm

Atlantic Medical Group
465 South Street, Suite 103 · Morristown, NJ 07960
phone: 973.971.7023 fax: 973.971.7159
email: amglegalrecordrequests@atlantichealth.org
Hours of Operation: Monday-Thursday 8am-4pm;
Friday 7am-3pm

Atlantic Visiting Nurse
465 South Street · Morristown, NJ 07960
phone: 973.921.8519 fax: 973.379.8435
email: avn.him@atlantichealth.org

NOT PART OF THE PERMANENT MEDICAL RECORD