RWJBarnabas HEALTH

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT LABEL

Patient Name	Date of Birth	Medical Record #	Contact Number
Address (Street, City, State, Zip Code)		Email Address	

Specify below the RWJBH location(s) that you want to release medical information; Provider name(s) (if known):_____

☐ ACC Imaging, Livingston	☐ Ambulatory Medical Pavilion, New Brunswick	☐ Cancer Institute of NJ	☐ Children's Specialized Hospital	☐ Clara Maass Medical Center
☐ Community Medical Center	☐ Cooperman Barnabas Med Ctr (formerly Saint Barnabas)	☐ Jersey City Medical Center	☐ Monmouth Medical Center	☐ Monmouth Medical Southern Center Campus
☐ Morris Cancer Center	☐ Newark Beth Israel Medical Center	☐ Plum Street Radiology	☐ RWJBH Behavioral Health Ctr	☐ RWJUH Hamilton
☐ RWJUH Rahway	☐ RWJUH Somerset	☐ RWJBH Medical Grp/Barnabas Health Med Group/RWJ Phys Ent	☐ Rutgers-RWJ Medical School	☐ RWJUH New Brunswick
				☐ Trinitas Regional Medical Center

I am requesting RWJBarnabas Health (RWJBH) including its affiliates to release my health information to:

Name of Organization/Recipient	Attn
Address (Street, City, State, Zip Code)	
Phone #/ and/or Fax # if applicable	Email Address if applicable

Method of Delivery:

☐ Paper to be picked up (hospitals only)	☐ Paper to be sent by US Mail to above address (☐ Package may be left without signature ☐ Signature Required for Delivery)	
☐ Encrypted Email to above email address	☐ Other electronic format to be mutually agreed upon	☐ MyChart

Information to be Released:

Requested date range: From: _____ **To:** _____			
☐ Demographics/Proof of Stay	☐ Therapy Evaluation/Treatment Notes	☐ Operative Reports	☐ Lab Reports
☐ Discharge Summary	☐ Emergency Dept Records	☐ Complete Medical Record	☐ Imaging Reports
☐ Billing Records	☐ Consultation(s)	☐ Pathology Reports	☐ Behavioral Health Initial Treatment Plan
☐ If applicable: pictures, images, video - must specify procedure(s) and date(s):			☐ Other (specify):

I understand that the information to be disclosed will include my identity and may include my testing, diagnosis, and treatment for **ALCOHOL, DRUGS, OTHER SUBSTANCE ABUSE DISORDER, GENETIC DISEASES AND/OR GENOMIC INDICATORS, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE HEALTHCARE, AIDS** and **HIV, SEXUALLY TRANSMITTED** and other **INFECTIOUS DISEASES**, as applicable.

Purpose of Release:

☐ Continuing Care/Treatment	☐ Personal	☐ Insurance	☐ Legal	☐ Other (specify):

This authorization will automatically expire in 180 days from the date of my signature below, unless I otherwise specify that this authorization will terminate on the following date, or upon the following event or condition: _____

I understand that this Authorization will remain in effect until it expires as set forth above, or I provide a written notice of revocation (cancellation) of this form sent to the attention of the Health Information Management Department (HIM) at one of the addresses listed below. The revocation will be effective promptly after HIM's receipt of my written notice, except I understand that RWJBH cannot take back any information that was shared before I cancel this form.

I understand that once my health information is shared as described in this form, it could be re-disclosed and may no longer be protected by federal and state confidentiality laws.

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

I understand that I can refuse to sign this form, and that my refusal will not affect the start, continuation or quality of my medical treatment, enrollment in a health plan, or eligibility for benefits.

If I have questions about the disclosure of my health information or want a copy of what is being disclosed under this form, I can contact the applicable Health Information Management Department at the addresses listed on the next page or:

E-Mail - RWJBHRegulatoryROI@rwjbh.org / Fax Number – 732-728-5040

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 RWJBarnabas Health to use and disclose my health information in the manner described above.

_____ _____ _____

Signature of Patient/Authorized Representative **Date Signed** **Print Name of Person Signing**

If the patient does not have legal capacity or is otherwise unable to sign this Authorization, please complete the information below:
(Please attach documents supporting relationship as Legal Guardian, Health Care Agent or another authorized Personal Representative)

_____ _____

Relationship to Patient **Date**

****

For Office Use Only:

ID checked: ☐ YES ☐ NO ID type: _____

Date Released:_____ Time:_____

Signature of Staff:_____ Printed Staff Name:_____

Medical Record Request Fees:

Medical records are provided at no cost when the records are sent to another healthcare provider for patient care. For all other requests, there may be a fee to the patient/requestor. Please ask Health Information Management for more information as to the fee applicable to your request and method of delivery.

For questions, contact the respective site Health Information Management department below:

Campus Name/ Address	Phone #	Fax#
Cancer Institute of New Jersey 195 Little Albany St, New Brunswick, NJ 08901	732-235-2465	732-235-7355
Children's Specialized Hospital 150 New Providence Rd, Mountainside, NJ 07092	908-301-5421	908-301-5527
Clara Maass Medical Center 1 Clara Maass Drive, Belleville, NJ 07109	973-450-2063	973-450-2608
Community Medical Center 99 Highway 37 West, Toms River, NJ 08755	732-557-8136	732-557-2209
Cooperman Barnabas Medical Center 94 Old Short Hills Rd, Livingston, NJ 07039	973-322-5835	973-322-5693
Jersey City Medical Center 355 Grand St, Jersey City, NJ 07302	201-915-2151 option 2	201-915-2556 201-915-2559
Monmouth Medical Center 300 2nd Ave, Long Branch, NJ 07740	732-923-7184	732-923-7620

NOTE: For medical group patients, please contact the office where you were treated. If a facility where you were treated is not listed above, Please contact that facility directly with any question or email RWJBHRegulatoryROI@rwjbh.org or send a fax to: 732-728-5040.

Campus Name/Address	Phone #	Fax#
Monmouth Medical Center Southern Campus 600 River Ave, Lakewood, NJ 08701	732-942-5634	732-942-5605
Newark Beth Israel Medical Center 201 Lyons Ave, Newark, NJ 07112	973-926-7409	973-926-7513
Plum Street Radiology **Ambulatory Medical Pavilion** **Morris Cancer Center** 10 Plum St, New Brunswick, NJ 08901	732-828-3000 Ext 34078	732-253-3401 732-418-8489
Robert Wood Johnson University Hospital at Hamilton 1 Hamilton Health Place, Hamilton, NJ 08690	609-584-6620 & 609-584-6623	609-245-7418
Robert Wood Johnson University Hospital New Brunswick 1 Robert Wood Johnson Pl, New Brunswick, NJ 08901	732-828-3000 Ext 32769	732-253-3401 732-418-8489
Robert Wood Johnson University Hospital Rahway 865 Stone St, Rahway, NJ 07065	732-499-6035	732-680-8974
Robert Wood Johnson University Hospital Somerset 110 Rehill Ave, Somerville, NJ 08876	908-685-2196	908-704-3762
RWJBH Behavioral Health Center 1691 US-9 CN 2025, Toms River, NJ 08753	732-942-5634	732-942-5605
Trinitas Regional Medical Center 225 Williamson Street, Elizabeth, NJ 07202	908-994-5315 & 908-994-5316	908-994-5256