Hackensack Meridian *Health*

RI0000

PATIENT LABEL

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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

I authorize Hackensack Meridian Health to release information to:

Organization/Recipient:	Attn:
Address (Street, City, State, Zip Code)	
Phone #:	Fax #:

Location of Services:

☐ Jersey Shore University Medical Center	☐ Hackensack University Medical Center	☐ Carrier Clinic	☐ Bayshore Medical Center
		☐ Raritan Bay Medical Center	☐ Palisades Medical Center
☐ JFK University Medical Center	☐ Southern Ocean Medical Center	☐ Old Bridge Medical Center	☐ Carrier Clinic
☐ Riverview Medical Center	☐ Ocean University Medical Center	☐ Other (specify):	

Information to Be Released:

Requesting records (date range): from: to:

☐ Clinic Notes	☐ Therapy Service Reports	☐ Operative/Procedure Notes	☐ Lab/Pathology Reports	
☐ Discharge Summaries	☐ Emergency Dept Records	☐ Radiology Images	☐ Radiology	☐ Reports
☐ Drug/Alcohol Records	☐ Abstract	☐ Other (specify):		

Purpose of Release:

☐ Continuing Care	☐ Personal use	☐ Transfer to another provider	☐ Legal	☐ Other (specify):

Release Requiring Specific Consent:

I specifically authorize HMH to release health information checked below:

☐ Reproductive Health Care	☐ Sexually Transmitted Diseases	☐ HIV/AIDS	☐ Mental Health	☐ Alcohol/Drug Abuse*

CONSENT OF MINOR

A minor patient's signature is required in order to release the following Information: 1) conditions relating to reproductive health care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 13 and older), 2) drug and alcohol abuse diagnosis or treatment, (age 13 and older), and 3) mental health conditions, psychotherapy (age 13 and older).

By signing this form, I certify that I am the individual to the patient whose protected health information as noted above is being requested for release:

Signature of Patient/Minor	Print Name	Date Signed

Requested Format:

☐ Paper	☐ Electronic Copy (encrypted USB, CD)	☐ Fax No:	☐ Secured email:

EHI Export - is a machine-readable format of your medical records which can be uploaded to another Electric Health Record (EHR). If you would like to request a copy of your records in a machine-readable format, please indicate by adding your initials here_____.

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I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by informing in writing the HMH Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below, unless another date or event is entered here _____.

By signing this form, I certify that I am the individual or legally authorized representative to the patient whose protected health information as noted above is being requested for release.

Signature of Patient or Legal Representative_____ Date Signed _____

Print Name_____ Relationship to Patient_____

Additional Information

FEE FOR COPYING MEDICAL RECORDS - There may be a fee for copying the medical records. Please ask the Health Information Management personnel for information about the fee schedule.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION - *Drug and Alcohol Abuse and Treatment Records are protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of this information 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR QUESTIONS, CONTACT RESPECTIVE SITE HEALTH INFORMATION MANAGEMENT

Hackensack Meridian Health Hospital Campus Health Information Department			
Campus	**Address**	**Phone #**	**Fax#**
Bayshore Medical Center	727 North Beers St. Holmdel, NJ 07730	732-739-5933 or 732-739-5985	732-888-7332
Carrier Clinic	252 Co Rd 601 Belle Mead, NJ 08502	908-281-1479	908-281-1671
Hackensack University Medical Center	30 Prospect Ave. Hackensack, NJ 07601	551-996-2074	551-996-2347
Jersey Shore University Medical Center	1945 HWY 33 Neptune, NJ 07753	732-776-4771	732-776-4692
JFK University Medical Center	65 James Street Edison, NJ 08820	732-321-7000 ext.62631 or 732-321-7177	732-549-8569
Ocean University Medical Center	425 Jack Martin Blvd. Brick, NJ 08724	732-840-3331	732-836-4269 or 732-840-9616
Palisades Medical Center	7600 River Road North Bergen, NJ 07047	201-854-5081 or 201-854-5083	201-854-8360 or 201-854-8546
Raritan Bay Medical Center	530 New Brunswick Ave. Perth Amboy, NJ 08861	732 324 5391	732-324-4883
Old Bridge Medical Center	3 Hospital Plaza Old Bridge, NJ 08857	732 360-4237	732-360-4134
Riverview Medical Center	1 Riverview Plaza Red Bank, NJ 07701	732-530-2510	732-224-7210
Southern Ocean Medical Center	1140 Route 72 West Manahawkin, NJ 08050	609-978 3820	609-978-8965