RWJ Physician Enterprise | **RWJBarnabas HEALTH**

PATIENT AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient's Name:_____
(Last) (First) (Middle)

Phone No:_____ DOB.:___/___/____
Month/Day/Year

Address:_____
(Street) (City) (State) (Zip code)

Please check all that apply:

I authorize RWJ Physician Enterprise to disclose medical information about my:

___Complete Medical Record **or**

___Specific Test & Date:_____**or** Service Date:_____

Records to be disclosed _____do include _____do not include HIV-related information
_____do include_____do not include Alcohol and Drug Abuse records
_____do include_____do not include Psychiatric Records

To: □ Healthcare Provider □ Self □ Attorney □ Court □ Law Enforcement □ Employer □ Mail Out □ Will Pick Up

Name:_____Address_____

Phone No._____Fax No._____

Requests must be submitted in writing to Robert Wood Johnson Physician Enterprise. When approved, the requested health information will be released within 30 days. A fee of $1.00 per page will be charged for copying. If the request is denied, the patient or patient representative will be informed as to the reason why. We will not condition treatment or payment on whether you sign this authorization. However, if you refuse to sign we will not release your records. I understand that this authorization is valid for maximum of one year from this date or until _____ and may be revoked by me at any time except to the extent RWJ Physician Enterprise has already taken action based on my authorization.

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infections, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the releases of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New Jersey Civil Rights Commission at (973)648-2700.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient/Legal Representative (Legal Representative to sign only if patient is a minor or unable to sign on his/her behalf)

Signature:_____**Print Name:**_____**Date:**_____

To Revoke Authorization Send a Written Request to:
Privacy Officer/Risk Management
Robert Wood Johnson Physician Enterprise
3 Executive Drive, Suite 400
Somerset, New Jersey 08873

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