

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): _____

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

<input type="checkbox"/> Paper to be picked up (hospitals only)	<input type="checkbox"/> Paper to be sent by US Mail to above address (<input type="checkbox"/> Package may be left without signature <input type="checkbox"/> Signature Required for Delivery)
<input type="checkbox"/> Encrypted Email to above email address	<input type="checkbox"/> Other electronic format to be mutually agreed upon <input type="checkbox"/> MyChart

Information to be Released:

Requested date range: From: _____ To: _____			
<input type="checkbox"/> Demographics/Proof of Stay	<input type="checkbox"/> Therapy Evaluation/Treatment Notes	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency Dept Records	<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Imaging Reports
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Behavioral Health Initial Treatment Plan
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Medical Abstract	<input type="checkbox"/> Provider Notes	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> If applicable: pictures, images, video - must specify procedure(s) and date(s):			

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:

<input type="checkbox"/> Continuing Care/Treatment	<input type="checkbox"/> Personal	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Other (specify):
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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 - 732-728-2040

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.