DT2201

PATIENT ID HERE

Atlantic Health System

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ **Morristown Medical Center** 100 Madison Avenue, Morristown, NJ 07960 T: 973-971-5183 • F: 973-290-7999 Email: mmhmedrec@atlantichealth.org	☐ **Newton Medical Center** 175 High Street, Newton, NJ 07860 T: 973-579-8365 • F: 973-383-4559
☐ **Overlook Medical Center** 99 Beauvoir Avenue, Summit, NJ 07901 T: 908-522-2113/2594 • F: 908-273-1272 Email: ohhealthrecords@atlantichealth.org	☐ **Chilton Medical Center** 97 West Parkway, Pompton Plains, NJ 07444 T: 973-831-5051 • F: 973-831-5257
☐ **Atlantic Medical Group** Name of Practice: _____ Address: _____ T: _____ • F: _____	☐ **Hackettstown Medical Center** 651 Willow Grove Street, Hackettstown, NJ 07840 T: 908-850-7727 • F: 908-850-6826

I do hereby consent to and authorize Atlantic Health System and _____ to disclose to the person(s) named, information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to the hospital and to its employees for the release of information as specified below.

PURPOSE _____ DATE: _____

PATIENT NAME: _____ PHONE: _____ DATE OF BIRTH: _____

TREATMENT DATES NEEDED: _____

SPECIFIED REPORTS/EDUCATION INFORMATION: *(Check appropriate boxes)*

☐ Abstract: face sheet, history & physical, discharge summary, all medical tests, operative section
☐ All Medical Tests: labs, ECG, x-ray, operative section
☐ HIV/AIDS treatment records *(if your information contains HIV/AIDS related information you must check this box)*
☐ Drug/Alcohol treatment records
☐ Psychiatric treatment records
☐ Genetic
☐ OTHER: _____

☐ Complete copy
☐ Certified Records
☐ Clinic
☐ Radiology Films
☐ Discharge Instructions
☐ Medication Reconciliation

*A fee for copying medical records will be invoiced to the patient or legally authorized representative in accordance with N.J.A.C. § 8:43G-15.3(d)(1)(2)(i)-(ii), HIPAA Privacy Standard § 164.524 (c) (4). When payment is received the records will be released. ** For continuing care purposes, there will not be a charge for records sent directly to a physician or facility. ** Processing time will vary due to the status of the record.*

RELEASED TO: Name: _____ Phone: _____

Address: _____ Zip: _____

Special Instructions: _____ To be: ☐ Picked up ☐ Mailed

Unless otherwise revoked by me, this Authorization is valid for 6 months from the date above. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this Authorization.

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 for benefits. AHS cannot guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

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 AHS to use or disclose my health information in the manner described above.

Patient Signature	Date	Signature of Witness
_____	_____	_____

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

Signature of authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative	Relationship	Date	Signature of Witness
_____	_____	_____	_____

Completed By: _____ **Date:** _____

NOTICE TO RECIPIENT OF INFORMATION

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules 42 C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.