



# AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION



HEALTH INFORMATION  
FAX: (201) 967-0340

### Patient Identification

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Information To Be Released – Covering the Periods of Health Care

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

### Please check type of information to be released:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Entire Medical Record           | <input type="checkbox"/> Pathology report      | <input type="checkbox"/> Discharge summary  |
| <input type="checkbox"/> History and physical exam       | <input type="checkbox"/> Consultation reports  | <input type="checkbox"/> Progress notes     |
| <input type="checkbox"/> Laboratory test results/reports | <input type="checkbox"/> X-ray reports         | <input type="checkbox"/> X-ray films/images |
| <input type="checkbox"/> Operative report                | <input type="checkbox"/> Emergency room record | <input type="checkbox"/> Itemized bill      |
| <input type="checkbox"/> Other, (specify) _____          |  |   |

### Purpose of Request

- Treatment or consultation     At the request of the patient     Billing or claims payment
- The following marketing purposes: \_\_\_\_\_
- Other, (specify) \_\_\_\_\_

### Payments to Facility

This marketing activity involves direct or indirect compensation/payment from a third party to Hackensack UMC at PV for this use of protected health information. **Check One:**  Yes  No \_\_\_\_\_ Initials

### Person Authorized to Receive Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

### Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:**  Yes  No \_\_\_\_\_ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. **Check One:**  Yes  No \_\_\_\_\_ Initials

### Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 250 Old Hook Road, Westwood, NJ 07675. Unless revoked, this authorization will expire on the following date or event \_\_\_\_\_.

### Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

### Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Hackensack UMC at PV may not condition my treatment on whether I sign this authorization form unless specified above under Purposes of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize Hackensack UMC at PV to use and disclose the protected health information specified above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authority to Sign if not patient: \_\_\_\_\_

Identity of Requestor Verified via:  Photo ID  Matching Signature  Other, specify \_\_\_\_\_

Verified by: \_\_\_\_\_

DO NOT WRITE IN THIS AREA

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