

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name (first & last)	Date of Birth	Medical Record #
Patient Street Address	City & State	Zip Code
Home Phone	Cell Phone	Fax #

I understand that by completing the information below and signing this Authorization for Release of Protected Health Information (“Authorization), I authorize Rutgers Health, **(INSERT Name of Practice/School/Institute HERE)** to release copies of my medical record as I direct below.

Please complete the information below to help us fulfill your request to release protected health information from your medical record—please be as specific as possible:

- Dates of Treatment:** Please provide the treatment dates you would like us to include in the release:
 Dates: _____

- Healthcare Provider:** Please tell us the name of your licensed healthcare provider and/or the name of the provider’s office:

- Medical Information:**
 - 3.1 Would you like the entire content of your Rutgers Health medical record released: yes no
 If no, please list the contents of your medical record for release: _____

 - 3.2 If the medical record requested above contains *any of the following* protected health information, you must check the boxes below to authorize release of the specific protected health information. If you **Do Not** check the boxes, any protected health information related to the boxes below contained in the requested record will not be released:
 - Psychiatric Treatment Mental Illness Drug Abuse Alcoholism HIV/AIDS
 - Communicable Diseases Sexually Transmitted Disease Test for Infection with HIV Genetic Information
 - DNA Test Results (specify name of DNA test) Substance use disorder counseling notes (must include all specific dates)
 - Psychotherapy notes (must include all specific dates) Reproductive health records

*Applicable copying fees may be applied, please contact the respective Rutgers Health department.

Send To/Recipient: Please tell us the name and address where the requested medical records are to be sent (the “Recipient”):

1. Name: _____
 Phone: _____
 Address: _____
2. Name: _____
 Phone: _____
 Address: _____
4. **Purpose:** The medical record being sent to the above Recipient is for the following purpose:
 - Personal Use by Patient Continuing Care Attorney/Legal
 - Other: _____

5. **Additional Important Information – Must review:**

- It is my intent that the use of the information provided to the above Recipient is prohibited for any other purpose other than the stated above (#4) and that the Recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.
- I understand that I have the right to revoke this Authorization at any time by submitting a written revocation to the Rutgers Health Practice/School/Institute listed above. I understand that if I do revoke my Authorization, my revocation will not apply to the extent Rutgers Health has already acted in reliance on this Authorization. **If not previously revoked, this Authorization will terminate/expire one (1) year from the date of patient’s signature.**
- I understand that authorizing this disclosure of my medical record and Protected health information is completely voluntary. I can refuse to sign this Authorization. I do not need to sign this form in order to receive treatment, payment, enrollment or eligibility for benefits.
- I understand that the uses and disclosures of my medical record and protected health information authorized by this Authorization may be subject to re-disclosure by the recipient noted above and may not be protected by privacy and confidentiality laws.
- I understand that if this Authorization is for marketing purposes that Rutgers Health may receive direct or indirect compensation.
- I understand that my medical records may include information about me obtained using advanced technologies, including but not limited to artificial intelligence and machine learning.
- If the requested medical record and Protected health information involves mental health information, I acknowledge and am aware that New Jersey has statutory privilege accorded to confidential communication between a patient and a licensed health care provider, such as a psychologist, and that signing this form authorizing the release of my information may waive that privilege.

PATIENT SIGNATURE: _____

DATE: _____

Legal representative, please sign below, state relationship, authority to do so and **attach the document of authority**.

SIGNATURE – LEGAL REPRESENTATIVE _____

DATE: _____

PRINT NAME – LEGAL REPRESENTATIVE _____

Relationship: _____

NOTICE TO RECIPIENT OF PROTECTED HEALTH INFORMATION

PROHIBITION ON RE-DISCLOSURE: this information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. **If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making 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.** A general authorization for the 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.