RUTGERS
BIOMEDICAL AND HEALTH SCIENCES

****Insert name of RBHS Practice/School/Institute ****

AUTHORIZATION FOR RELEASE OF PERSONAL 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 Personal Health Information ("Authorization), I authorize Rutgers Biomedical and Health Sciences to release copies of my medical record as I direct below.

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

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

2. **Healthcare Provider**: Please tell us the name of your licensed healthcare provider and/or the name of the provider's office:
   _____
   _____

3. **Medical Information**:
   3.1 Would you like the entire content of you RBHS 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 personal health information, you must check the boxes below to authorize release of the specific personal health information. If you **Do Not** check the boxes, any personal 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)**
   _____

4. **Recipient/Sent to**: 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:_____

5. **Purpose**: The medical record being sent to the above Recipient for the following purpose:
   □ Personal Use by Patient □ Continuing Care □ Attorney/Legal
   □ Other:_____

6. **Additional Important Information** – Please review:

It is my intent that the use of the information furnished is prohibited for any other purpose other than the stated above 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.

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I understand that I have the right to revoke this Authorization at anytime by submitting a written revocation to the Practice listed above. I understand that my revocation will not apply to the extent the Practice has already taken action 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 personal 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 RBHS may receive direct or indirect compensation.

If the requested medical record and personal 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 CRF 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.

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