



AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record Number: _____

Address: _____

Date of Birth: _____ Phone Number: _____

**PERSON/ORGANIZATION
PROVIDING INFORMATION:**

**UNDERWOOD-MEMORIAL HOSPITAL
HEALTH INFORMATION MANAGEMENT DEPARTMENT
Address: 509 N. BROAD ST. WOODBURY, NJ 08096
Phone: (856) 853-2021**

**PERSON/ORGANIZATION
RECEIVING INFORMATION:** _____

Address: _____

Phone: _____ FAX: _____

PURPOSE OF DISCLOSURE:

- Legal
- Insurance
- Employer
- Further medical care
- Personal use
- Other (please specify): _____

DATES OF TREATMENT:

INFORMATION REQUESTED:

- Emergency Dept Record
- Lab results
- Pathology reports
- X-ray/medical imaging
- EKG/cardiac studies
- Discharge Summary
- History and Physical
- Operative Record
- Consultation Reports
- Entire Record
- MICU/Paramedic
- Physical Medicine
- Behavioral Health
- Medication Records
- Outpatient Records
- Other (please specify): _____

I understand that:

- ❖ *The information in my health record may include information about behavioral or mental health services, or treatment for alcohol and drug abuse. It may also include information related to genetic testing, treatment or testing for sexually transmitted disease, HIV or AIDS.*
- ❖ *This authorization is voluntary and I do not need to sign this form to ensure healthcare treatment.*
- ❖ *I may inspect or copy the information used or disclosed under this authorization.*
- ❖ *Once this information is disclosed, it may be redisclosed by the person or organization receiving the information and that information may no longer be protected by federal privacy laws or regulations.*
- ❖ *I have the right to revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that this revocation will not apply to information that has already been released.*
- ❖ *This authorization will expire in ninety (90) days from the date signed below; or upon the following date, event or condition:*

Signature of Patient or Legal Representative _____ **Date:** _____

If signed by legal representative, please indicate relationship to patient _____

For UMH Use:

Date received:	<input type="checkbox"/> ID verified	Method of Disclosure:	Completed by:	Date completed:
		<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> In person pick up		