



**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

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

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

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PERSON/ORGANIZATION**

**PROVIDING INFORMATION:** Family Medicine Center

Address: 75 W. Red Bank Avenue, Woodbury, NJ 08096

Phone: (856) 853-2055 FAX: (856) 848-2879

**PERSON/ORGANIZATION**

**RECEIVING INFORMATION:** \_\_\_\_\_

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

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**PURPOSE OF DISCLOSURE:**

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> Legal     | <input type="checkbox"/> Further medical care | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal use         | _____  |
| <input type="checkbox"/> Employer  |   |  |

**DATES OF TREATMENT:**

**INFORMATION REQUESTED:**

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

***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		