



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



**HEALTH INFORMATION
FAX: 973-680-7910**

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 Mountainside Medical Center 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 1 Bay Avenue Montclair, NJ 07042. 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 Mountainside Medical Center 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 Mountainside Medical Center 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: _____

ROI (09/2013) 1.1

DO NOT WRITE IN THIS AREA

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