



R1000

PATIENT LABEL

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

CMR-003 (11-28-22) PAGE 1 OF 2

Patient Name	Date of Birth	Medical Record #	Contact Number
Address (Street, City, State, Zip Code)			

I authorize Hackensack Meridian Health to release information to:

Organization/Recipient:	Attn:
Address (Street, City, State, Zip Code)	
Phone #:	Fax #:

Location of Services:

<input type="checkbox"/> Jersey Shore University Medical Center	<input type="checkbox"/> Hackensack University Medical Center	<input type="checkbox"/> Carrier Clinic	<input type="checkbox"/> Bayshore Medical Center
<input type="checkbox"/> JFK University Medical Center	<input type="checkbox"/> Southern Ocean Medical Center	<input type="checkbox"/> Raritan Bay Medical Center	<input type="checkbox"/> Palisades Medical Center
<input type="checkbox"/> Riverview Medical Center	<input type="checkbox"/> Ocean University Medical Center	<input type="checkbox"/> Old Bridge Medical Center	<input type="checkbox"/> Carrier Clinic
<input type="checkbox"/> Other (specify):			

Information to Be Released:

Requesting records (date range): from:		to:	
<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Therapy Service Reports	<input type="checkbox"/> Operative/Procedure Notes	<input type="checkbox"/> Lab/Pathology Reports
<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> Emergency Dept Records	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Radiology <input type="checkbox"/> Reports
<input type="checkbox"/> Drug/Alcohol Records	<input type="checkbox"/> Abstract	<input type="checkbox"/> Other (specify):	

Purpose of Release:

<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Personal use	<input type="checkbox"/> Transfer to another provider	<input type="checkbox"/> Legal	<input type="checkbox"/> Other (specify):
--	---------------------------------------	---	--------------------------------	---

Release Requiring Specific Consent:

I specifically authorize HMH to release health information checked below:				
<input type="checkbox"/> Reproductive Care	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Alcohol/Drug Abuse*

CONSENT OF MINOR

A minor patient's signature is required in order to release the following Information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 13 and older), 2) drug and alcohol abuse diagnosis or treatment, (age 13 and older), and 3) mental health conditions, psychotherapy (age 13 and older).

By signing this form, I certify that I am the individual to the patient whose protected health information as noted above is being requested for release:

Signature of Patient/Minor

Print Name

Date Signed

Requested Format:

<input type="checkbox"/> Paper	<input type="checkbox"/> Electronic Copy (encrypted USB, CD)	<input type="checkbox"/> Fax No:	<input type="checkbox"/> Secured email:
--------------------------------	--	----------------------------------	---



R1000

PATIENT LABEL

**AUTHORIZATION TO USE OR
DISCLOSE PROTECTED HEALTH
INFORMATION**

CMR-003 (11-28-22) PAGE 2 OF 2

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by informing in writing the HMH Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below, unless another date or event is entered here _____.

By signing this form, I certify that I am the individual or legally authorized representative to the patient whose protected health information as noted above is being requested for release.

Signature of Patient or Legal Representative _____ Date Signed _____

Print Name _____ Relationship to Patient _____

Additional Information

FEE FOR COPYING MEDICAL RECORDS - There may be a fee for copying the medical records. Please ask the Health Information Management personnel for information about the fee schedule.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION - *Drug and Alcohol Abuse and Treatment Records are protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of this information from making any 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR QUESTIONS, CONTACT RESPECTIVE SITE HEALTH INFORMATION MANAGEMENT

Hackensack Meridian Health Hospital Campus Health Information Department			
Campus	Address	Phone #	Fax#
Bayshore Medical Center	727 North Beers St. Holmdel, NJ 07730	732-739-5933 or 732-739-5985	732-888-7332
Carrier Clinic	252 Co Rd 601 Belle Mead, NJ 08502	908-281-1479	908-281-1671
Hackensack University Medical Center	30 Prospect Ave. Hackensack, NJ 07601	551-996-2074	551-996-2347
Jersey Shore University Medical Center	1945 HWY 33 Neptune, NJ 07753	732-776-4771	732-776-4692
JFK University Medical Center	65 James Street Edison, NJ 08820	732-321-7000 ext.62631 or 732-321-7177	732-549-8569
Ocean University Medical Center	425 Jack Martin Blvd. Brick, NJ 08724	732-840-3331	732-836-4269 or 732-840-9616
Palisades Medical Center	7600 River Road North Bergen, NJ 07047	201-854-5081 or 201-854-5083	201-854-8360 or 201-854-8546
Raritan Bay Medical Center	530 New Brunswick Ave. Perth Amboy, NJ 08861	732 324 5391	732-324-4883
Old Bridge Medical Center	3 Hospital Plaza Old Bridge, NJ 08857	732 360-4237	732-360-4134
Riverview Medical Center	1 Riverview Plaza Red Bank, NJ 07701	732-530-2510	732-224-7210
Southern Ocean Medical Center	1140 Route 72 West Manahawkin, NJ 08050	609-978 3820	609-978-8965