Hackensack Meridian *Health* Carrier Clinic
P O Box 147 Belle Mead, New Jersey 08502 Phone: 908-281-1479 Fax: 908-281-1671 E-mail: CC-HIM@hackensackmeridian.org

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:		
Date of Birth:	Social Security No:	Patient Number (Internal Use):
Email:	Phone #:	

Release Information To:			
Name:		Relationship to Patient:	
Address:	City:	State:	Zip:
Telephone No:	Fax No:		
Purpose of disclosure: ☐ Continuation of care ☐Family Involvement in Treatment ☐ Legal ☐ Insurance ☐PCP ☐School ☐ Preauthorization of Treatment ☐ Other:			

Information To Be Released:	
☐ Verbal Communication (Limited to) _____	
Treatment Dates needed:	
☐ Abstract: (This is what a physician usually needs for care. It includes a history and physical, test results (i.e. X-ray, labs, EKG), consultations, patient discharge instructions and discharge summary, if applicable.	
☐ Psychiatric Admission Evaluation ☐ Social Assessment ☐ Physical Examination / Consultations ☐ Progress Notes ☐ Master Treatment Plan ☐ ECT Records (from Carrier Clinic) ☐ Lab / Test Results / X-rays / Scans	☐ Medication Administration Record (MAR's) ☐ Psychological Testing / Evaluation ☐ Discharge Summary/PDI- Discharge Instructions (Discharge Packet) ☐ Face Sheet ☐ Admission / Discharge Date Letter ☐ Disability Forms ☐ Other) _____

PLEASE INITIAL ALL THAT APPLY: Release of Specific Information – By initialing here, I authorize HMH Carrier Clinic to release information regarding: (Minor is considered emancipated if any of the below apply.)		
Alcohol Use/Abuse _____	Substance Use/Abuse _____	HIV/AIDS _____ (13 years and older)
Pregnancy _____	STDs _____	Sexual Assault _____

Acknowledgements:

*I understand that this authorization expires one year from the date of signature below or sooner if I provide a written revocation to HMH Carrier Clinic.
*I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to HMH Carrier Clinic receiving the revocation.
*I understand that I may refuse to sign this authorization and that it is strictly voluntary.
*I understand that I may request a copy of this form after I sign it.
*I understand that my treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
*Any information disclosed which is protected under Federal confidentiality rules (42 CFR Part 2) will be treated as specified by such rules.
*I understand that information disclosed under this authorization may be re-disclosed by the recipient and in case of such re-disclosure, the information may not be protected by federal privacy laws or regulations.
*This authorization is limited to information contained in my medical record and does not include psychotherapy notes. If needed, a separate authorization is required to disclose psychotherapy notes.
*I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee. I understand that HMH Carrier Clinic may deny this request under limited circumstances and that HMH Carrier Clinic will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request.
*I understand that if I have further questions or concerns regarding my Protected Health Information, I may contact HMH Carrier Clinic's Privacy Officer.
*I understand that this authorization is valid for this visit and cannot be used for any subsequent visits. Those visits will need a new authorization signed.
***I understand the risks related to confidentiality inherent in the use of technology (i.e., information may not reach the person for whom it is intended, or may reach someone else for whom it was not intended, may be stored or forwarded without authorization). Despite this risk, I request that my records be transmitted as indicated. ☐ Mail ☐ Fax ☐E-mail**

Authorization Signature: I have read the above and authorize HMH Carrier Clinic to disclose the protected health information as stated.

Signature of Patient: (Signature required for all patients age 14 or older):	Date:	
Signature of Patient's Representative:	Date:	Relationship to Patient:
Witness:	Date:	Relationship to Patient:

(Enlarged copy of) Acknowledgements:

*I understand that this authorization expires one year from the date of signature below or sooner if I provide a written revocation to Carrier Clinic.
*I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to Carrier Clinic receiving the revocation.
*I understand that I may refuse to sign this authorization and that it is strictly voluntary.
*I understand that I may request a copy of this form after I sign it.
*I understand that my treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
*Any information disclosed which is protected under Federal confidentiality rules (42 CFR Part 2) will be treated as specified by such rules.
*I understand that information disclosed under this authorization may be re-disclosed by the recipient and in case of such re-disclosure, the information may not be protected by federal privacy laws or regulations.
*This authorization is limited to information contained in my medical record and does not include psychotherapy notes. If needed, a separate authorization is required to disclose psychotherapy notes.
*I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee. I understand that Carrier Clinic may deny this request under limited circumstances and that Carrier Clinic will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request.
*I understand that if I have further questions or concerns regarding my Protected Health Information, I may contact Carrier Clinic's Privacy Officer.
*I understand that this authorization is valid for this visit and cannot be used for any subsequent visits. Those visits will need a new authorization signed.
***I understand the risks related to confidentiality inherent in the use of technology (i.e., information may not reach the person for whom it is intended, or may reach someone else for whom it was not intended, may be stored or forwarded without authorization). Despite this risk, I request that my records be transmitted as indicated.**
☐ Mail ☐ Fax ☐ Email