MERIDIAN HEALTH

AUTHORIZATION FOR RELEASE OF INFORMATION

RI0000

Patient Name _____

Address (number and street) _____

City, State, Zip Code _____ **Telephone** _____

Date of Birth _____ Medical Record # _____

☐ **I hereby authorize and request Meridian Health to release information related to treatment at:**

☐ Bayshore Community Hospital ☐ Jersey Shore University Medical Center ☐ Ocean Medical Center ☐ Riverview Medical Center

☐ Southern Ocean Medical Center ☐ Meridian Health Partner ☐ Other Meridian Facility (specify)_____

☐ *I authorize Meridian Health* **to obtain records from**: _____

_____

(Name of facility / provider and address)

The Purpose of the Release _____

Disclose Information to: _____

Name/ Facility _____

Address _____

City, State, Zip _____

Telephone#_____ **Fax number** _____

Information to be Released/Obtained

(Please check appropriate areas) and Type of Visit and Specify Treatment Date(s)

☐ Inpatient, Admission Dates _____

☐ Emergency Dept (not admitted) Date(s)_____

☐ Same Day/Outpatient Procedure Date(s)_____

☐ Outpatient (specify departments in which seen) _____ ☐ Clinic_____ ☐ Cardiovascular ☐ Phys. Therapy

☐ Speech & Hearing _____ ☐ Other (specify) _____

(specify dept. and dates)

Specified Reports:

☐ Abstract (Face Sheet, Discharge Summary, H&P, ED, Consults, OP Report, Pathology, Lab and Diagnostic Studies)

☐ Admission/Face Sheet	☐ Doctor's Orders	☐ Medication Sheets	☐ Radiology Films
☐ Cardiology Report	☐ Emergency Dept	☐ Mental Health Consults/Evaluations	☐ Radiology Report
☐ Complete Medical Record	☐ History and Physical	☐ Nurses Notes	☐ Radiation Therapy
☐ Consultation Report	☐ Immunization Record	☐ Operative Report	☐ EEG
☐ Discharge Summary	☐ Interdisciplinary Notes	☐ Pathology Report	☐ _____
☐ Doctor's Notes	☐ Laboratory Report	☐ Pathology Slides/Specimens	☐ _____

*Complete record includes: all patient information listed under Specific Reports.

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type

I understand that this will include information relating to (check if applicable):

_____ **AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection**

_____ **Psychiatric Care** _____**Genetic Information** _____**Communicable Disease(s)**

_____**Treatment for alcohol and/or drug abuse** _____**Sexually Transmitted Disease(s)**

I authorize the above person/organization and /or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expire on _____**.** **If I fail to specify**

(Insert date or event)

an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative **Date** **Time AM/PM**

_____ _____

If signed by Legally Authorized Representative, Relationship to Patient Signature of Witness Date Time AM/PM

NOTICE TO RECIPIENT OF INFORMATION

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CRF Part 2) prohibits you from making 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. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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ALL REQUESTS WILL BE PROCESSED IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS

Copies will be provided within thirty days of a proper written request.

Receipt of specimen (if applicable)
NOTE: Certain substances relating to this specimen may be considered carcinogenic, biohazardous, toxic or irritant material. Biohazardous is identified as material that may contain blood-borne pathogens that are potentially infectious.
I have read this warning label on the specimen and I am aware of the risk in exposure to these substances.

Signature of Person Receiving Sample_____**Date**: _____ **Time:**_____**am/pm**

For MH Department Use Only:

If the patient is a minor, a parent, next of kin or legal guardian must sign the authorization, with the following exceptions and as prohibited by law:
• The minor is pregnant. • The minor is married. • The minor is emancipated (court determined)
• The treatment is a state funded mental health service. • The treatment is for Drug and/or Alcohol Abuse.
• The treatment is for a Sexually Transmitted Disease. • The treatment is for AIDS or HIV.

If patient is deceased, proof of executor or administrator of estate is required, if not applicable surrogate certificate.

IDENTIFICATION VERIFIED VIA:
☐ DRIVER'S LICENSE ☐ GOVERNMENT ISSUED ID Verified By:_____

IF COPIES ARE HANDCARRIED, OBTAIN SIGNATURE BELOW:

Signature: _____ **Date:** _____ **Time:**_____**am/pm**