



Authorization for Release of Information

Patient Name _____
Address (number and street) _____
City, State, Zip Code _____ Telephone _____
Date of Birth _____
Email address _____

I authorize Hackensack Meridian *Health* Medical Group to release my health information to:

Name _____
Address _____
City, State, Zip _____
Telephone # _____ Fax # _____

I authorize Hackensack Meridian *Health* Medical Group to obtain records from:

(Name of provider and address)

This authorization applies to the following information:

____ Complete Medical Record
____ Other (Please list) _____

The purpose of the release is:

____ For treatment purposes
____ At the request of the patient
____ Other (please specify) _____

_____ I authorize the above provider and members of its staff to furnish the information, including copies or faxed copies, as directed in this authorization. I further agree to release the provider 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 on it. I understand that this authorization will expire on _____, and if I fail to specify 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 re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative

Date

If signed by Legally Authorized Representative, Relationship to Patient

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 regulations may prohibit 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 federal regulations.