SHORE MEDICAL CENTER

Somers Point, NJ 08244

MRN: _____

FIN(s): _____

_____

_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip Code: _____

Phone Number: _____

Information to be released to (recipient): [ ] Check if same as patient

Recipient Name/Facility/Name of Organization: _____

Address: _____City: _____ State: _____ Zip Code: _____

Phone number: _____ Attention to: _____

Purpose (please check one): [ ] Continuation of care (Physician/Facility) [ ] Personal [ ] Legal

[ ] Insurance [ ] Other, specify: _____

Request Delivery Type (please check one): [ ] US Mail (paper) [ ] Pick Up (*ID Required*) [ ] CD/disk

[ ] Fax (unsecure): _____ [ ] Encrypted Email *: _____

In the event SMC is unable to accommodate your delivery method chosen above, we will reach out to you about alternative methods available.

NOTE: *Choosing encrypted email delivery involves some level of risk. We are not responsible for unauthorized access to the protected health information (PHI) contained in this format, or any risks (e.g., virus) potentially introduced when receiving PHI in electronic format by email or fax.*

Dates of Treatment/Service: _____/_____/_____ to _____/_____/_____

I specifically authorize the following PHI to be released from my record:

[ ] Abstract (*most common*): discharge summary, history & physical, consult(s), test results, Procedure Notes, ED

[ ] Emergency Department (ED) Visit

[ ] Hospital Admission/Inpatient Visit

[ ] History & Physical [ ] Discharge Summary [ ] Discharge Instructions

[ ] Operative/Procedure Reports [ ] Medication Record [ ] Consultation(s) [ ] Laboratory

[ ] Cardiology/Radiology Reports [ ] Face sheet [ ] Other, specify _____

[ ] Outpatient Visit

[ ] Laboratory [ ] Radiology [ ] Vascular [ ] Rehabilitation (i.e. physical, cardiopulmonary)

[ ] Endoscopy [ ] Other, specify _____

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_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that my medical record may contain information related to some of the health information listed below. **Please add your initials to the line next to the specific information you do NOT want released:**

_____ AIDS/HIV Treatment Records
_____ Behavioral Health Records
_____ Treatment for Alcohol and/or drug abuse
_____ Sexually transmitted Disease Testing
_____ Tuberculosis Test Results

_____ Genetic Testing/Treatment Records
_____ *Reproductive Health Care Services

*Defined as all medical, surgical, counseling or referral services related to the human reproductive system, including but not limited to, services relating to pregnancy, contraception, or termination of a pregnancy (NJSA 2A:84A-22.18)

Patient Authorization: I understand that:

- Unless revoked by me, this authorization will remain in effect for 90 days from the date above: I may revoke this authorization at any time by notifying the SMC in writing to **HIMS Department, Shore Medical Center, 100 Medical Center Way, Somers Point, NJ, 08244 Attention: ROI** I also understand that such a revocation will not have any effect on any information already used or disclosed by SMC prior to SMC receiving my written notice of revocation. In addition, refusal or revocation will not affect my ability to obtain treatment, insurance payment or eligibility benefits.
- Once SMC discloses my protected health information to the recipient, SMC cannot guarantee that the recipient will not disclose my PHI to a third party. The third party may not be required to abide by the authorization or applicable federal and state law governing the use and disclosure of my health information.
- By my signature below, I hereby, knowingly and voluntarily, authorize SMC to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Personal Representative Date Signed

_____ _____
Print Name of Assisting SMC Staff Member Date

Please note: Shore Medical Center may charge for providing copies in accordance with New Jersey law, as applicable.

Mail completed form to: Shore Medical Center, 100 Medical Center Way, Somers Point, NJ 08244, Attn: HIMS/ROI

FOR SMC USE WHEN INFORMATION IS RELEASED: EXCEPTIONS REQUESTED? [ ] YES [ ] NO

Date released: _____/_____/_____ Signature of SMC Staff Member: _____

Total pages: _____ Total Charge: _____

THE PATIENT RECEIVED A PHOTOCOPY OF THIS COMPLETED FORM? [ ] YES [ ] NO, PATIENT DECLINED