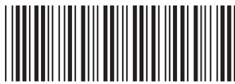

MI0015

CentraState Medical Center
901 West Main Street, Freehold, NJ 07728-2549

Authorization for Release of Health Information

PATIENT LABEL HERE

PATIENT NAME:	
MEDICAL RECORD #:	DATE OF BIRTH:
SOCIAL SECURITY #:	PHONE #:
HOME ADDRESS:	

1. TYPE OF REQUEST: I hereby request that CentraState Medical Center provide me with:
☐ Access to Review Originals ☐ Photocopies of my health information, as requested below:

2. INFORMATION TO BE RELEASED: *(include discharge date(s), date(s) of service, etc.)*

____
____
____
____
____

3. DESCRIPTION OF INFORMATION TO BE RELEASED: *(Check ALL that apply)*

☐ Abstract* (defined below)	☐ History and Physical	☐ Operative Reports	☐ Billing Records
☐ ER Record	☐ Progress Notes	☐ X-rays	☐ Entire Medical Record
☐ Outpatient Records	☐ Consultation Reports	☐ EKG/EEG	☐ Other *(specify)*:
☐ Discharge Summary	☐ Pathology Reports	☐ Labs	____________

*(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)*

4. SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE:
By signing my **initials** next to the specific category of highly confidential information, I am authorizing CentraState Medical Center to release the specific type of information described next to my initials that is, or may be, included under the treatment date(s) listed above.

_________ HIV/AIDS Related Information _________ Sexually Transmitted Disease Information

_________ Behavioral Health Records _________ Genetic Information

_________ Drug and Alcohol Information _________ Tuberculosis Information

5. RELEASE INFORMATION TO:
☐ Myself (the patient or authorized representative) ☐ To Organization/individual below:

ORGANIZATION:		INDIVIDUAL NAME:		PHONE #:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:	☐ Please mail ☐ Please prepare for pick-up

6. PURPOSE OF RELEASE:
I authorize CentraState Medical Center to release my health information for the following specific purpose:

____

7. TERM/EXPIRATION: This signed Authorization will expire in 6 months unless an earlier date is indicated by you below. Please list a date or event when this Authorization will no longer be valid *(This date cannot be more than 6 months in accordance with CentraState Medical Center's policy).* This Authorization will no longer be valid after: ____________

8. FEES
(apply to photocopies provided to patients or their authorized representatives only; other fees may apply to other requestor):
I understand that CentraState Medical Center has determined its actual costs to be equal to or greater than the following, but that, under New Jersey law, the fees may not exceed:

$1.00 per page (for the first 100 pages) and
$0.25 per page thereafter up to a maximum of $200.00 per record

MR 600-008 (12/4/14)

CONFIDENTIAL

I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or of use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law.

I understand that CentraState Medical Center may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have any denial of my request reviewed by a licensed health care practitioner selected by CentraState Medical Center who did not participate in CentraState Medical Center's decision to deny my request.

I understand that CentraState Medical Center 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.

The information to be disclosed from your records is confidential and is protected by federal and state laws. I understand that, once CentraState Medical Center releases my health information to the recipient listed on this Authorization, CentraState Medical Center cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that this Authorization will remain in effect until the terms of this Authorization expires or I provide a written revocation to CentraState Medical Center's Assistant Privacy Officer at the address listed below. The revocation will be effective immediately upon CentraState Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by CentraState Medical Center in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about my rights to access my health information and any Protected Health Information that CentraState Medical Center uses to make decisions about me. I also understand that if I have further questions or concerns regarding my Protected Health Information, I may contact CentraState Medical Center's Privacy Officer by mail at 901 West Main Street, Freehold, NJ 07728, by e mail at SEllison@centrastate.com, or by telephone at 732-294-2760.

I hereby authorize CentraState Medical Center to release/disclose the health information listed above for the purposes described in this Authorization.

Patient Signature: ______________________________ Date: ______________

If the patient is a minor or otherwise unable to sign this Authorization, then obtain the signature of the legally authorized representative/individual below.

Description of Authority: ______________________________

Signature: ______________________________ Date ______________

– NOTICE TO RECIPIENT OF INFORMATION –

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials under part 4 of this form, the following Notice applies to the information you have received pursuant to this authorization.

This information has been disclosed to you from records protected by Federal confidentiality rules 42 CFR Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for 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.

ORIGINAL - Patient's Medical Record; COPY - Patient