UNIVERSITY HOSPITAL
Newark, New Jersey

Health Information Management
150 Bergen Street, B417
Newark, NJ 07101-6750
(973) 972-5604

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Please PRINT (except signature) and all sections must be completed.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Telephone Number: _____

1. I authorize University Hospital to disclose my medical records to:

   _____

   _____

   (Name and address of person or institution to whom the disclosure is made)

2. This authorization is limited to the following dates of treatment:

   FROM: _____ TO: _____

   Information to be disclosed:

   _____

   _____

   (Provide specific type of records or request "complete medical record," note billing records must be requested separately)

3. Purpose of disclosure: ❑ Medical Care ❑ Legal ❑ Insurance ❑ Other: _____

4. **I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable. If you wish not to release any of the above mentioned inform please indicate below. Otherwise this information will be released.**

   Do not release the following: _____

5. This authorization may be revoked at any time by sending written notice to the Director of Health Information Management at the above address, except to the extent that University Hospital has already taken action in reliance on it. If not previously revoked, this authorization will automatically expire one year from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: _____

6. 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, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Signature of patient or legal guardian: _____ Date: _____

Relationship, if not the patient: _____

Note: Please mail completed form to address noted above.