MEDICAL CENTER

AUTHORIZATION FOR ACCESS/RELEASE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________ Medical Record Number: ____________

Date of Birth: ____________ Phone Number: ____________

Home Address: ____

1. **TYPE OF ACCESS/RELEASE/DISCLOSURE:** I hereby authorize **JFK Medical Center** to provide:
   ☐ Access to review Health Information ☐ Photocopies of my Health Information, as requested below:

2. **DATES/DESCRIPTION OF INFORMATION TO BE RELEASED/DISCLOSED:**

   (*Check ALL that apply*)

   ☐ ER Record Only ☐ History & Physical ☐ Operative Reports ☐ Entire Medical Record
   ☐ Outpatient Record Only ☐ Progress Notes ☐ X-Rays Reports ☐ Billing Records
   ☐ Discharge Summary ☐ Consultation Reports ☐ EKG/EEG Reports ☐ Other (Specify): ________
   ☐ Abstract (Face Sheet, History & Physical, Consults, Discharge Summary, Tests, Operative Reports, Lab/Pathology) ☐ Pathology Reports ☐ Lab Reports

   DATE(s) OF SERVICE: ____________

3. **SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE/DISCLOSURE:**
   By signing my initials, I understand that the information to be released/disclosed from my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), genetic information and tuberculosis information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
   Patient Initials: ________

4. **RELEASE/DISCLOSURE OF INFORMATION TO:** ☐ Myself (the patient or representative) ☐ To organization/individual below:

   ____________ \ ____________ ____________
   Organization Individual Name Phone

   ____________ ____________ ____________ ____________ ☐ Please mail
   Street Address City State Zip Code ☐ Please prepare for pick-up

5. **PURPOSE OF RELEASE/DISCLOSURE:** I authorize **JFK Medical Center** to release/disclose my health information for the following specific purpose(s): ☐ Medical Care ☐ Insurance ☐ Personal
   ☐ Other: ______________________

6. **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 may not be more than 6 months in accordance with JFK'S policy).* This authorization will no longer be valid after: ____________

7. I understand that I have a right to revoke this authorization at any time.

- I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Services Department.
- I understand that the revocation will not apply to information that has already been released/disclosed in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that authorizing the release/disclosure of this health information is voluntary.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

8. I understand that JFK may deny this request under limited circumstances as provided 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 a denial of my request reviewed by a licensed health care practitioner selected by JFK, who did not participate in JFK's decision to deny my request. I understand that JFK 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.

9. 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 JFK uses to make medical decisions about me. I also understand, that if I have further questions or concerns regarding my Protected Health Information, I may contact the SOLARIS Privacy Officer by mail at: 65 James Street, Edison, NJ 08818 By Telephone at: (732) 321-7000, Ext. 65888

10. I hereby authorize the access/release/disclosure of my individually identifiable health information, as described above. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal privacy regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Patient Signature: ______________________ Date: ______________

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

Description of Authority: ______________________ Date: ______________

Signature: ______________________ Date: ______________
(other than patient)

- 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 2. 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 C.F.R. 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 C.F.R. 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

R-6/17/03

Affiliates of SOLARIS Health System
JFK Medical Center • Muhlenberg Regional Medical Center • JFK Johnson Rehabilitation • New Jersey Neuroscience Institute
JFK Hartwyck Nursing, Convalescent & Rehabilitation Centers • Muhlenberg School of Nursing, Medical Imaging & Therapeutic Sciences
Mediplex Surgery Center • Diabetes Center of New Jersey • Whispering Knoll – Assisted Living
65 James Street, P.O. Box 3059, Edison, New Jersey 08818-3059 (732) 321-7000 www.solarishs.org