SOLARIS
HEALTH SYSTEM

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

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

____________ ____________ ____________ ____________
Street Address City State Zip Code

☐ Please mail
☐ 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

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

This authorization must be dated and signed by the individual or by a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original (unless applicable state law provides otherwise). If UnitedHealthcare seeks the authorization from an individual for a use or disclosure of PHI, UnitedHealthcare must provide the individual with a copy of the signed authorization.

I authorize United Healthcare Insurance Company, and its subsidiaries/affiliates ("UnitedHealthcare"), to use or disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records, as described below. I understand these records may contain information created by other persons or entities, including health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services [Note: psychotherapy notes may be used/disclosed only pursuant to a separate authorization pertaining only to psychotherapy notes], reproductive health services, and treatment for sexually transmitted diseases.

1. Persons/entities authorized to receive the information (including address of where information should be sent, if applicable):

   Name: ______________________________

   Address: ______________________________

2. Type of information UnitedHealthcare is authorized to use or disclose:

   ____

   ____

3. The information will be used or disclosed for the following purposes:

   ____

4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment in the health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment for treatment, unless allowed by law.

5. I understand that I may revoke this authorization at any time by notifying UnitedHealthcare in writing at PO Box 740800, Atlanta, GA 30374, except to the extent that:
   (a) We have taken action in reliance on this authorization; or
   (b) If authorization was obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

6. This authorization expires [on] [upon] _______________[date] or is valid _____________ [event]. Please note: this authorization may be valid for a maximum time period of one year.

7. UnitedHealthcare may receive compensation from a third party for using or disclosing this information.

I understand that once health information about me has been disclosed by United Healthcare Insurance Company to a third party, the health information may no longer be protected by federal privacy laws.

____
Printed name of individual or individual's representative

____
If representative, relationship to individual and authority to act for individual

______________________________ ______________ ______________
Signature of individual **Subscriber Id #** **Subscriber Date of Birth**

Subscriber Address:______________________________

Form: AUTH UNI 102203