University HOSPITAL
Newark, NJ

150 Bergen Street, B417 • Newark, NJ 07103
Health Information Management • Phone: (973) 972-5604

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Please PRINT (except signature) and provide complete information in each section.

Patient Name: _____ Birthdate: _____ Social Sec #: _____

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

Name: _____ Address: _____

_____
(person or Institution to whom disclosure is made)

2. The portion(s) of my medical records that I want disclosed include: _____

_____
(please provide treatment dates, where treatment was provided, types of records to be excluded, if any)

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

I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV), that my signing this document authorizes University Hospital to release that information. I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communication between a patient and a licensed physician or psychologist and that my signing this form waives this privilege.

☐ **A check here indicates that I believe my medical records may contain DNA test results or other genetic information. Such Information is specially protected by New Jersey law, and I will be contacted for separate, specific consent prior to release of this Information.**

4. This authorization may be revoked at any time by sending written notice to the Director of Health Information Management, University Hospital, 150 Bergen Street B-439, Newark, NJ 07103, except to the extent that University Hospital has already taken action in reliance on it. If not previously revoked, this consent will terminate upon _____ .
(indicate date or an expiration event.)

5. University Hospital will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

6. I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws.

7. I understand that I may be charged for copies of my medical records ($1.00 per page).

Signature of patient or legal guardian: _____ Date: _____

Relationship, if not the patient: _____

Note: Please mail completed form to address noted above.