University HOSPITAL
Newark, NJ

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

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

All sections must be completed.
Please PRINT (except signature).

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City/State: _____ Zip Code: _____ Phone #: _____

1. I authorize University Hospital to disclose my medical records to: (I want my records to go to:)

Name: _____

Address: _____

City/State: _____ Zip Code: _____ Phone #: _____

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

FROM: _____ TO: _____

If exact dates are not known, please provide an approximate time frame.

3. Information to be disclosed: (What records do you want?)

- ❑ Emergency Room Record
- ❑ Clinic Notes
- ❑ Abstract/Hospital Summary
- ❑ Laboratory Report(s)
- ❑ Radiology Report(s)
- ❑ Operative Report(s)
- ❑ Complete Medical Record (all pages)
- ❑ Radiology Film(s)/Image(s)
- ❑ EMS / Ambulance Report(s)
- ❑ Other: _____

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

5. How would you like your records delivered?

- ❑ Paper (❑ Home Delivery or ❑ In Person Pickup)
- ❑ Fax to Doctor (Fax #: _____)
- ❑ Electronic - select one below:
  - ❑ Secure email (provide email address): _____
  - ❑ CD
  - ❑ Send to my UH MyChart account

6. **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, please indicate below. Otherwise this information will be released.**

Do not release the following: _____

7. 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: _____

8. 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 / Authorized Representative: _____ Date: _____

Printed Name of Legal Guardian / Authorized Representative: _____

Relationship, if not the patient: _____

If signed by a patient's legal guardian / authorized representative, supporting legal documentation MUST accompany this authorization form.

For Office Use Only:

MR #: _____ Request ID: _____