Holy Name Medical Center

718 Teaneck Road
Teaneck, NJ 07666

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize you to furnish to:

☐ Physician ☐ Insurance Co. ☐ Legal ☐ Hospital ☐ Other

Doctor's Appt. Date _____
Time _____ AM / PM (when applicable)

Name: _____
Address: _____
_____

Phone #: _____
Fax #: _____

information, access to, or photocopies of the medical records of:

Patient's Name: _____
Address: _____
_____

MR #: _____
Birth Date: _____
Phone #: _____

The foregoing is subject to the limitations as listed below:

1. Nature of information to be released:

☐ history/physical exam	☐ discharge summary	☐ consultative reports
☐ operative reports	☐ pathology report(s)	☐ x-ray reports
☐ laboratory reports	☐ physical therapy notes	☐ progress notes
☐ nurses notes	☐ Emergency Department records	☐ other: _____

2. This authorization is confined to the following dates of treatment: from _____ *(month/date/year)* to _____ *(month/date/year)*
3. Purpose of release: _____

Sensitive Information: I understand that the information released from my medical record may include information relating to sexually transmitted diseases, HIV/AIDS related information (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such test were positive or negative). It may also include information about behavioral or mental health services, drug and alcohol information, genetic information and tuberculosis information. I approve of the release of such information by initialing:

HIV/AIDS _____ Drug or Alcohol _____ Mental Health _____ Genetics _____

***Please note, all copies for patient records for personal use carry a per page fee. The State of New Jersey allows 30 days to comply with a record request and walk-ins will be handled accordingly unless there is an emergency.** If you are picking up the records personally, you will be required to show a legal form of identification.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the rule.

I further direct that only information prior to the date of my signature below be honored, and that a photocopy of this authorization be granted the same authority as the original.

I further hereby release Holy Name Medical Center and you personally from all legal responsibility and/or liability that may arise from the release of such records as specified above, and I hereby waive all rights I have to preserve their confidentiality.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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. Unless otherwise revoked, this authorization will expire in one year's time. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

Signature of Patient: _____ *Date:* _____

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signature:

Signature of Patient Representative: _____ *Date:* _____

Description of Authority: _____
(Please note, a copy of the legal documents must be provided in order to prove authority if not signed by the patient.)