AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

INFORMATION MAY BE DISCLOSED/RELEASED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED/RELEASED TO:

Person/Facility: _____ Phone # _____

Address: _____ Fax #: _____

Other method of communication: _____

INITIAL – I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO: Date Range: _____

____ General Medical Records ____ History & Physicals ____ Progress Notes ____ Family Planning

____ Mental Health (excluding psychotherapy notes) ____ Substance Use Disorders ____Sexually Transmitted Diseases

____ Psychotherapy Notes: If selected, no other item on this form may be selected. A separate form must be completed. Psychotherapy notes use or disclosure is at the discretion of the author of the note.

____ Diagnostic Test Reports (Specify type of test): _____

____ HIV/AIDS related information and treatment ____ ***HIV/AIDS related information may be sent via fax***

____ Other: _____

____ All of my health information that the providers have in their possession, including information relating to any medical history, mental health (excluding psychotherapy), or physical condition and any treatment received by me

PURPOSE OF DISCLOSURE: ☐ Continuity of Care ☐ Personal Use ☐ Other (specify): _____

EXPIRATION DATE: This authorization will expire (insert date or event)_____. I understand that I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Notice to Patient: By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed above. Our Notice of Privacy Practices provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. You understand that the above information may be redisclosed by the recipient and may not be protected by federal privacy laws or regulations. Any information covered under 42 CFR part 2 will not be redisclosed. You understand that completing this authorization form is voluntary and that treatment will not be denied if you refuse to sign this form. You may request a list of protected health care information disclosures made on your behalf.

You have the right to **revoke** your authorization by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this authorization. You are entitled to a copy of this **authorization form** after you have signed it.

NJ - If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New Jersey Civil Rights Commission at (973) 648-2700

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Relationship to Client

_____ _____

Witness (Optional) Date

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

Last Revised 12/15/2020