SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM
254 Easton Avenue
New Brunswick, NJ 08901
732-745-8600 · www.saintpetershcs.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

HEALTH INFORMATION MANAGEMENT DEPARTMENT

Telephone (732) 745-8511 Fax Number (732) 729-9476

Patient Name:_____ Date of Birth:_____ Telephone #:_____

Home Address: _____

Medical Record Number: _____ Account Number: _____

TYPE OF REQUEST: I hereby request that Saint Peter's University Hospital provide me with:

☐ **Copies of** my Health Information, as requested below: ☐ **Access** to Review Originals
(Note that if access is requested, it is subject to review at a time and place chosen by the Hospital.)

RELEASE INFORMATION TO: ☐ Myself (the patient or representative) ☐ To organization/individual below:

Organization	Individual Name	Phone	
Street Address	City	State	Zip Code

DATES OF SERVICE FOR WHICH PROTECTED HEALTH INFORMATION IS TO BE DISCLOSED:

Date(s) _____

INFORMATION TO BE RELEASED: (check all that apply)

☐ Medical Abstract*	☐ Discharge Summary	☐ Surgery Reports
☐ Emergency Dept Records Only	☐ History and Physical	☐ X-Rays
☐ Outpatient Records Only	☐ Progress Notes	☐ EKG/EEG
☐ Consultation Reports	☐ Pathology Reports	☐ Labs

☐ Other: _____

- ***Medical Abstract includes***: *Face Sheet, Discharge Summary, Emergency Room Records, History & Physical, Consultations, Laboratory, Radiology, EKG, Operative Report, Pathology Report.*

DELIVERY METHOD: (check one)

☐ Please mail
☐ Please copy for pick-up
☐ Please provide electronically (for health information contained in an Electronic Health Record ("EHR").
[Patient/Authorized Representative: also complete HealthPort Electronic Record Delivery Request and fax with authorization.]
USB Flash Drive Password: _____

SPECIFIC CONFIDENTIAL INFORMATION:
Please sign your initials next to those specific categories of highly confidential information that you authorize Saint Peter's University Hospital to release for the treatment date(s) above. *If a line is **NOT** initialed, that information will **NOT** be released.*

_____ HIV/AIDS Information	_____ Mental Health/Psychotherapy Information	_____ Drug/Alcohol Information
_____ Genetic Information	_____ Sexually Transmitted Disease Information	_____ Tuberculosis Information

PURPOSE OF RELEASE: I authorize Saint Peter's University Hospital to release the above Health Information for the following Purpose(s): _____

TERM/EXPIRATION: This Authorization is valid for a period of **ninety (90) days** ("Term"), unless a shorter term is stated here: _____, and therefore expires on ___/___/___.

FEES: (apply to copies given to patients and their legally authorized representatives only; other fees may apply to other requestors): I accept that Saint Peter's University Hospital, Inc. is able under state and federal law to charge me a fee for electronic copies or photocopies and any applicable mailing/postage fees for my medical records. I further accept that these copy fees are based on the current hospital fee schedule in keeping with New Jersey law.

I accept that information given to me based on this request will not include information compiled in anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be prohibited by law.

I accept that Saint Peter's University Hospital may deny this request on a limited basis under federal and state law protecting the privacy of health information. I further accept that, except as otherwise prohibited under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Saint Peter's University Hospital who did not take part in Saint Peter's University Hospital's finding to deny my request.

I accept that Saint Peter's University Hospital will notify me of its finding to approve or deny my request to access or obtain a copy of the requested information within thirty (30) days of getting this request.

The information to be disclosed from my records is confidential and is protected by federal and state law. I accept that once Saint Peter's University Hospital releases my health information to the person(s) listed on this Authorization, Saint Peter's University Hospital cannot guarantee that the person(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I accept that this Authorization will stay in effect until its Term expires, or I provide a written repeal to Saint Peter's University Hospital. The repeal will be effective immediately upon Saint Peter's University Hospital receipt of my written notice, except that the repeal will not have any effect on any action taken by Saint Peter's University Hospital in good faith before Saint Peter's University Hospital received my written notice of repeal.

I have read, understand and accept the terms describe in 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 Saint Peter's University Hospital uses to make medical decision about me. I also understand that if I have further questions or concerns about my Protected Health Information, I may contact Saint Peter's University Hospital Health Information Management Department by mail: 254 Easton Avenue, New Brunswick, New Jersey 08901 or by telephone at (732) 745-8511 or by **FAX # (732) 729-9476.**

I hereby authorize Saint Peter's University Hospital to release/disclose the health information as listed for the purposes as written in this Authorization.

Patient Signature: _____ Date: _____ Time: _____

If the patient is a minor or otherwise unable to sign this Authorization, then the signature of the patient's legally authorized representative must be recorded below:

Description of Authority: _____

Representative Signature: _____ Date: _____ Time: _____

Interpreter/Translator: _____ Date: _____ Time: _____

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.