Medical Record Services (Release of Information)
100 Madison Ave, Morristown NJ 07960
T: 973-971-5183 Fax: 973-290-7999
Email: mmhmedrec@atlantichealth.org

DT2201

Morristown Medical Center

PATIENT ID HERE

AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby consent to and authorize Atlantic Health or _____ to disclose to the person(s) named, information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to the hospital and to its employees for the release of information as specified below.

PURPOSE _____ DATE: _____

PATIENT NAME: _____ PHONE: _____ DATE OF BIRTH: _____

TREATMENT DATES NEEDED: _____

SPECIFIED REPORTS: *(Check appropriate boxes)*

☐ Abstract: face sheet. history & physical, discharge summary, all medical tests, operative section
☐ All Medical Tests: labs, ekg, xray, operative section
☐ HIV/AIDS Treatment records *(if your information contains HIV/AIDS related information you must check this box)*
☐ Drug/Alcohol Treatment records
☐ Psychiatric treatment records
☐ Genetic
☐ OTHER: _____

☐ Complete copy
☐ Certified Records
☐ Clinic

*A fee for copying medical records will be invoiced to the patient or legally authorized representative in accordance with N.J.A.C.§ 8:43G-15.3(d)(1)(2)(i)-(ii), HIPAA Privacy Standard Section 164.524 (c) (4). When payment is received the records will be released. ** for continuing care purposes, there will not be a charge for records sent directly to a physician or facility. ** Processing time will vary due to the status of the record.*

RELEASED
TO: Name: _____ Phone: _____

Address: _____ Zip: _____

Special Instructions: _____ To be: ☐ Picked up ☐ Mailed

Unless otherwise revoked by me, this authorization is valid for 6 months from the date above. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this authorization.

I understand that once AH discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, AH cannot guarantee that Recipient will not redisclose 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 have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize AH to use or disclose my health information in the manner described above.

_____ _____ _____
Patient Signature | Date | Signature of Witness

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Signature of authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative | Relationship | Date | Signature of Witness

NOTICE TO RECIPIENT OF INFORMATION

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules 42C.F.R.Part2. 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 42C.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.