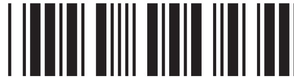
AtlantiCare
REGIONAL MEDICAL CENTER

☐ AtlantiCare Regional Medical Center
☐ AtlantiCare Behavioral Health
☐ AtlantiCare Health Services
☐ AtlantiCare Surgery Center
☐ AtlantiCare Physicians Group
☐ Other ____________________


542

Patient Name: ____________________

Address: ____________________

Address: ____________________

Date of Birth: ____________________

Patient Phone No.: ____________________

MRN (if known): ____________________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the AtlantiCare entity indicated below:

☐ AtlantiCare Regional Medical Center	☐ AtlantiCare Behavioral Health	☐ AtlantiCare Health Services
☐ AtlantiCare Surgery Center	☐ AtlantiCare Physicians Group	☐ Other: ____________

To release the health information of: ____________________ ____________________
Patient Name **Date of Birth**

To the person or entity listed below:

Recipient's name: ____________________

Recipient's Address: ____________________

____

Recipient's Telephone: ____________________ Recipient's Fax: ____________________

Information to be released from records pertaining to: ☐ Inpatient ☐ Outpatient Recipient's Email: ____________________

☐ Abstract of Medical Record	☐ Clinic Notes	☐ ER Notes	☐ Lab Reports
☐ Complete Medical Record	☐ EEG, EKG, Stress Test	☐ Itemized Bills	☐ Radiology Films/Reports
☐ Discharge Summary	☐ Immunizations	☐ Pathology Reports	☐ Other
☐ History & Physical	☐ Operative Reports	☐ Mental Health	
☐ Medications	☐ Alcohol/Substance Use Disorder*	☐ Consultation Reports	
☐ HIV/AIDS	☐ Colonoscopy	☐ Endoscopy	

If you would like any of the following sensitive information disclosed, check the applicable box(es) below*:

☐ Alcohol/Drug Abuse Treatment/Referral	☐ Reproductive Health Care Services	☐ Mental Health (Other than Psychotherapy Notes)
☐ Sexually Transmitted Diseases	☐ HIV/AIDS-related Treatment	

*As defined by N.J.S.A. 2A:84A-22.18 -Reproductive health care services means all medical, surgical, counseling, or referral services relating to the human reproductive system including, but not limited to, services relating to pregnancy, contraception, or termination of a pregnancy.

For date(s) of service: ____________________

Reason for disclosure of health information: ☐ Personal ☐ Treatment/Coordination of Care ☐ Other ____________________

NOTICE TO PATIENT

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with this request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies. I understand that I am not required to sign this authorization and AtlantiCare may not condition treatment on my execution of this authorization. I understand that the information disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by HIPAA. The authorization will expire upon the release of the information described above or four (4) months after the date of the authorization, unless otherwise specified.

Expiration Date: ____________________

NOTICE TO RECORDS RECIPIENT*

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder and/or reproductive health care services either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or otherwise permitted by 42 CFR Part 2 as well as N.J.S.A. 2A:84A-22.18. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder.

Expiration Date: ____________________

Patient's Signature (Ages 14 and Older) ____________________ **Date:** ____________

Parent/Legal Guardian/Patient Representative Signature: ____________________ **Date:** ____________

Witness Signature: ____________________ **Date:** ____________

Patient is entitled to a copy of signed authorization.

Oral consent given ____________________ **Date:** ____________
Employee Signature