Jefferson Health®

Authorization to Release Protected Health Information

Section 1: Patient Information

PATIENT NAME		SOCIAL SECURITY NO. **LAST 4 DIGITS ONLY**		DATE OF BIRTH
PATIENT ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

Section 2: Location(s) of Care

☐ Jefferson Cherry Hill Hospital ☐ Jefferson Stratford Hospital ☐ Jefferson Washington Township Hospital
☐ Other (if other location is selected - provide the specific location, address or physician practice/name where you received care):

_____

_____

_____

Section 3: Release Records To:

I hereby consent to and authorize the above entities to release information from my medical record to:

Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self:

Address: Telephone No:

Fax No:

For the Purpose of:

☐ Continuation of Care ☐ Social Security Disability ☐ Insurance Purposes ☐ Legal Purposes
☐ Lay Caregiver ☐ Benefits Assignment ☐ School Registration ☐ Camp Registrations
☐ Personal Access ☐ Other: _____

Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

Section 4: Specific Information to Be Released

The information to be released will cover the time period from _____ to _____.

SPECIFIC INFORMATION TO RELEASE:

☐ **Abstract*** ☐ Discharge Summary ☐ Physician Orders
☐ Office Notes/Visit Notes ☐ Operations Report ☐ Imaging Films (X-rays, Scans, CD)
☐ Discharge Instructions ☐ Pathology Reports ☐ Photographs
☐ Immunizations ☐ Consultation Reports ☐ Itemized Bills
☐ Disability/FMLA Form ☐ Laboratory Results ☐ Catheterization Lab
☐ Medication List ☐ Imaging Reports ☐ Reproductive Health Care Services
☐ Problem List ☐ ECG, EEG, Stress Tests ☐ Emergency Room Record
☐ History & Physical Exams

☐ Other (specify) _____

☐ Exception: I do not give permission to release (specify): _____

* An **abstract** is a composite of the record that is most helpful to our patients and contains the information that is sent to physicians for continuity of care. The abstract contains the discharge summary, history and physical, consultation reports, all operations, diagnostic and laboratory results.

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Section 5: Special Authorizations For Mental Health, Drug and Alcohol and HIV Records

ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION

I understand that my medical record may contain "protected information" related to the following categories. This protected information is being disclosed from records whose confidentiality is protected by the below Federal and State Laws. My signature next to these items acknowledges my awareness and my authorization to release "protected information" in the record.

_____
Signature

Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician/provider. (Confidential Alcohol and Drug Abuse Patient Information 42 C.F.R. Part II)

_____
Signature

Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician/provider. (N.J. Division of Mental Health and Addiction Svc.)

_____
Signature

HIV related information for individuals 12 years or older, if HIV-related tests were ordered by my physician/provider.
NJ Code (N.J.A.C. 13:35-6.5 (3)(c).

Section 6: Authorization Signatures

AUTHORIZATION SIGNATURES

I hereby authorize Thomas Jefferson University (TJU), including the clinical operations referred to as Jefferson Health, which includes, Kennedy University Hospital, Inc., Jefferson Medical Group and the above mentioned locations to disclose the health information as described above.

I understand the nature of this authorization and understand that it is voluntary. My refusal to sign this form in no way affects my treatment, payment, enrollment in health plans or eligibility for benefits, except: (a) when this authorization is for the use or disclosure of health information obtained in a research study, or (b) when I have requested a service by Jefferson (for example, a medical second opinion) and the sole purpose of the service is to provide health information to a third party at my request.

I understand that I may revoke this authorization at any time by sending a written request to the address indicated on the back of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. I have a right to request a copy of this authorization. A copy of this authorization is as valid as the original.

Authorization Expires *(insert date or event)*

☐ 1 year from date of authorization ☐ Other Date or Event (please specify): _____

If no expiration date is designated this authorization will expire six (6) months from the signature date.

Patient Signature: _____ Date Signed: _____

Signature of Parent/Legal Guardian/Authorized Representative: _____

Printed Name of Parent/Legal Guardian/Authorized Representative: _____

Unable to sign because: _____

Verbal Consent *(If the patient is physically unable to provide a signature. A verbal consent may be revoked by a verbal statement verified in writing by two witnesses.)* I witness that the patient was physically unable to provide a signature, but that he/she understood the nature of this release and freely gave his/her oral authorization.

_____	_____	_____
Witness Signature	Witness Printed Name	Date
_____	_____	_____
Witness Signature	Witness Printed Name	Date

☐ Attached is a copy of the appropriate legal document, which proved authority to act on behalf of the patient.
Records of deceased patients: If the requester is not the executor of the decedent's estate or if there is no executor or administrator then the requester certifies by signing above that he/she is the next of kin responsible for the disposition of the decedent's remains and the attached legal documentation confirms the above statement.

Instructions for Completing the Authorization for Release of Protected Health Information Form

1. **Please complete all sections of the Authorization for Release of Protected Health Information Form.**

2. **The patient or legally authorized representative must sign and date the form.**

   Jefferson may require proof of representation if the form is signed by a personal representative. For minors (under 18 years), a parent or legal guardian must sign, with the following exceptions:
   - emancipated minors may sign this form (a patient who has left the parental household, supports him/herself financially, and lives independently);
   - emancipated minor includes a minor who has been married, has entered military service, has a child or is pregnant, or has previously been declared by a court or administrative agency to be emancipated may also sign this form;
   - minors may authorize release of PHI related to pregnancy, sexually transmitted diseases, or substance abuse treatment; and
   - minors 14 years or older may authorize release of their mental health treatment records, provided the patient understands the nature of the information and the reason for use or disclosure.

3. **Please mail the completed form to:**

Jefferson Cherry Hill Hospital **Health Information Management** **2201 Chapel Avenue West** **Cherry Hill, NJ 08002** **Phone:(856) 406-4850** **Fax: (856) 488-3578** **Hours of Operation:** **Monday – Friday 8:00 a.m. – 4:30 p.m.**	**Jefferson Health Stratford Hospital** **Health Information Management** **18 E. Laurel Road** **Stratford, NJ 08084** **Phone:(856) 406-4850** **Fax: (856) 488-3578** **Hours of Operation:** **Monday – Friday 8:00 a.m. – 4:30 p.m.**	**Jefferson Health Washington Township** **Health Information Management** **555 Egg Harbor Road** **Sewell, NJ 08080** **Phone:(856) 406-4850** **Fax: (856) 488-3578** **Hours of Operation:** **Monday – Friday 8:00 a.m. – 4:30 p.m.**
Jefferson Health Care Center **535 Egg Harbor Road** **Sewell. NJ 08080** **Phone: (856) 557-0100** **Fax: (856) 589-2154** **Monday - Friday 8:00 a.m.-4 p.m.**	**Other:** _____ _____	

4. **Please Note:**

Jefferson will charge for copying records in accordance with State and Federal Laws. § 8:43G-15.3 Medical record patient services

Jefferson will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.

ANY COPIES OF MEDICAL RECORDS THAT ARE SENT VIA FED-EX, UPS, ETC. WILL REQUIRE A SIGNATURE UPON DELIVERY.

If the person or entity receiving the health information is not a health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

Jefferson may deny this request under limited circumstances as provided for under federal or state law. Jefferson will notify you if it denies your request to access or obtain a copy of the requested information. If Jefferson denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.