SHORE MEDICAL CENTER

Somers Point, NJ 08244

PATIENT ID/LABEL HERE:

AUTHORIZATION FOR RELEASE OF INFORMATION
(USED TO SEND SMC RECORDS TO THE PATIENT OR THEIR DESIGNEE)

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

Daytime Phone Number: _____

Information to be released to (receiver): [ ] Check if same as patient

Recipient Name/Facility/Name of Organization: _____

Address: _____

Phone number: _____Fax number: _____ Attention to: _____

Purpose: [ ] physician or other healthcare provider [ ] Personal Use [ ] Legal [ ] Insurance

[ ] Other, specify: _____

Request Delivery Type: [ ] Paper [ ] Electronic Media (CD/disk) [ ] US Mail [ ] Pick Up

[ ] Fax Number: _____ [ ] Encrypted Email ***:** _____

In the event SMC is unable to accommodate your delivery method chosen above, we will reach out to you about alternative methods available.

****NOTE:** *Encrypted email delivery involves some level of risk. We are not responsible for unauthorized access to the PHI contained in this format, or any risks (e.g. virus) potentially introduced when receiving PHI in electronic format or via email.*

Dates of Treatment/Service: _____

I specifically authorize the use/disclosure of the following health information:

[ ] Abstract (*most common*): face sheet, discharge summary, history & physical, consult(s), test results Procedure Notes, Emergency Room

[ ] Emergency Room Visit

[ ] Hospital Admission/Inpatient Visit

[ ] Entire Chart [ ] History & Physical [ ] Discharge Summary [ ] Discharge Instructions

[ ] Operative/Procedure Reports [ ] Medication Record [ ] Consultation(s) [ ] Laboratory

[ ] Cardiology/Radiology Reports [ ] Face sheet

[ ] Outpatient Visit – Department: [ ] Laboratory [ ] Radiology [ ] Cardio Vascular [ ] Rehab (Phys. Therapy, Pulmonary [ ] Endoscopy [ ] other, specify _____

INFORMATION OF THE BELOW NATURE WILL BE RELEASED UNLESS YOU SPECIFICALLY INITIAL ITEMS NOT TO BE RELEASED. I understand that my medical record may contain information related to some of the following

_____ AIDS/HIV Treatment Records
_____ Behavioral Health Records
_____ Treatment for Alcohol and/or drug abuse
_____ Sexually transmitted Disease Testing
_____ Tuberculosis Test Results
_____ Genetic Testing/Treatment Records

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PATIENT ID/LABEL HERE:

Patient Authorization: I understand that:

- Unless revoked by me, this authorization will remain in effect for 90 days from the date above: I may revoke this authorization at any time by notifying the SMC in writing to **HIMS Department, Shore Medical Center, 100 Medical Center Way, Somers Point, NJ, 08244 Attention: HIMS/ROI**
  I also understand that such a revocation will not have any effect on any information already used or disclosed by SMC prior to SMC receiving my written notice of revocation. In addition such refusal or revocation will not affect the commencement, continuation or quality of my treatment at SMC.
- Once SMC discloses my PHI to the recipient, SMC cannot guarantee that the recipient will not disclose my PHI to a third party. The third party may not be required to abide by the authorization or applicable federal and state law governing the use and disclosure of my health information.
- I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize SMC to use or disclose my PHI in the manner described above.

Signature of Patient	Date Signed
Signature of Personal Representative	Date Signed
Print Name of Assisting SMC Staff Member	Date

FOR SMC USE WHEN INFORMATION IS RELEASED: **EXCEPTIONS REQUESTED? YES NO**

Date released: _____/_____/_____ Signature of SMC Staff Member: _____

Total pages: _____ Total Charge: _____

THE PATIENT RECEIVED A PHOTOCOPY OF THIS COMPLETED FORM? YES NO, PATIENT DECLINED

Mailing Address: Shore Medical Center, 100 Medical Center Way, Somers Point, NJ 08244, Attn: HIMS/ROI