SHORE MEDICAL CENTER

Somers Point, NJ 08244

PATIENT ID/LABEL HERE:

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE PROVIDE THE PATIENT WITH A PHOTOCOPY OF THIS COMPLETED FORM

Patient Information:

Patient Name: ______________________________

Maiden Name/Alias: ______________________________

Date of Birth: ______________ Social Security Number: ______________

By signing this authorization form, I authorize Shore Medical Center (SMC) to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below to the following person or organization:

Name of person/organization: ______________________________

Street address: ______________________________

City: ______________ State: __________ Zip Code: __________

Telephone number: ______________ Facsimile number: ______________

Purpose of use/disclosure: ______________________________

I specifically authorize the use/disclosure of the following PHI: (***Please provide a detailed description of the particular dates and timeframes of your treatment)***

☐ Emergency Records ______________________________

☐ Hospital Records/Inpatient Records: ______________________________

- ☐ Face sheet
- ☐ Discharge Summary
- ☐ Consent to transfer
- ☐ Other: ______________________________
- ☐ History and Physical
- ☐ Operative Report(s)
- ☐ Progress Notes
- ☐ Social Service/DC Planning Notes
- ☐ Drug/Medication Records

☐ Clinic/Outpatient Records:______________________________

☐ Laboratory Report(s): ______________________________

☐ Pathology Report(s): ______________________________

☐ Radiology Report(s): ______________ ☐ Radiology Images: ______________

☐ Consultation Report(s): ______________________________

☐ EKG/Cardiac Report(s): ______________________________

☐ Other: ______________________________

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I understand that my medical record may contain information related to some of the following:

_____ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
_____ Psychiatric information
_____ Treatment for Alcohol and/or drug abuse
______ Venereal disease information
______ Tuberculosis information
______ Genetic information

NOTE: INFORMATION OF THE ABOVE NATURE WILL BE RELEASED UNLESS YOU SPECIFICALLY INITIAL ITEMS NOT TO BE RELEASED.

I understand that once SMC discloses my PHI to the recipient, SMC cannot guarantee that the recipient will not redisclose 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 may revoke this authorization at any time by notifying the SMC in writing to **HIMS Department, Shore Medical Center, 1 East New York Avenue, Somers Point, NJ, 08244**.

However, 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.

If you believe your privacy rights have been violated, or you disagree with a decision we made about access to your protected health information, you may contact the SMC Privacy Office by calling 1-866-314-4722 or 1-609-926-4300 or at the above listed address to the attention of the Privacy Office.

Term of Authorization: This authorization will remain in effect for 90 days unless otherwise specified below: (*Initial the applicable box)*

_____ From the date of this authorization until the ____________ day of ___________, 201__
_____ Until the following event occurs: ____

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. 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:

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

Total pages: ____________________ Total Charge: ________________

PROVIDED THE PATIENT A PHOTOCOPY OF THIS COMPLETED FORM? ☐ **YES** ☐ **NO, PATIENT DECLINED**