Deborah® Heart and Lung Center

Authorization to Release Patient Information

Department of Medical Records – Telephone: 609-893-4645 Fax: 609-893-5953.
This request will not be processed unless all areas are completed.

Patient Name_____

Address_____

Date of Birth_____

I, hereby authorize Deborah Heart and Lung Center to release my health information described below:

To _____

Address_____

Phone_____

Service date_____

Documents/Information to be released, please be specific:(note: only a medical summary of your visit will be released, unless specific tests are requested) _____

_____

_____

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_____

Purpose of disclosure, please explain or indicate "at the request of the individual."

_____

continued...

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this authorization, at any time prior to the Center's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in the Center's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to: **Deborah Heart and Lung Center, Medical Record Dept., 200 Trenton Rd., Browns Mills, NJ 08015.**

I understand that I am not required to sign this authorization and that the Center may not condition treatment (payment, enrollment in a health plan or eligibility for benefits) on my execution of this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires upon Covered Entity's release of information described above or thirty days after the Date of Authorization, as set forth below, whichever comes first.

Additionally, and in accordance with State mandated regulation, hereby consent to release/disclosure to the recipient named above information listed from my medical record relating to my identity, diagnosis, prognosis, treatment and/or condition related to: psychological or psychiatric impairment; drug abuse and/or alcohol abuse; Sickle Cell Anemia; Acquired Immunodeficiency Syndrome (AIDS) and or test for infection with Human Immunodeficiency Virus (HIV).

NOTE: Hereby making this request, I understand that any/all records requested to be sent to anyone OTHER THAN my medical doctor, I will be charged $1.00 per page not to exceed $100 for the entire record. There may be a $10 charge for CDs.

I hereby acknowledge receipt of a copy of this Authorization (if requested).

_____

Signature of Individual or Personal Representative

_____

Description of Personal Representative's Authority

_____

Patient Social Security Number and Date of Birth_____

Date of Authorization_____

Authorization expires six months from this date.

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