NJ Spine and Orthopedic

HEALTH RECORD RELEASE

AUTHORIATION TO RELEASE, REQUEST, OR OBTAIN CONFIDENTIAL INFORMATION

By signing this authorization, I authorize NJ Spine and Orthopedic to use and/or disclose certain protected health information, (PHI), about me to or for the party or parties listed below.

I, _____, Date of Birth: _____, SSN: _____,
hereby authorize NJ Spine and Orthopedic to **[ ] OBTAIN [ ] RELEASE** medical information via, mail, facsimile, or other appropriate source **[ ] TO [ ] FROM:**

_____
(Person(s) or Entity(s) to receive/release requested information)

_____
(Address) (City, State, Zip) (Phone Number) (Fax Number)

I. The individually identifiable health information to be obtained/released is: (Please a √ in appropriate space(s)).

_____ All Records / Information (reports, phone notes, testing, therapy, billing, etc only)
_____ Entire Medical chart (Specify if cover to cover requested)
_____ X-Ray, Laboratory or other Diagnostic Reports
_____ Emergency Room Records from _____(Date)
_____ Inpatient Records from _____(Date)
_____ Therapy notes
_____ Medication List(s)
_____ Financial Information

_____ Only the period of events from _____to _____ (Date)
_____ Only information related to (Specify) _____
_____ Other (Specify) _____

Additional information to obtain/release: (Please place a √ in appropriate spaces(s)).

_____ Psychological Records / Information ____ Drug / Substance Abuse ____ HIV results, information

- Alcohol, drug abuse information, etc, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. Additionally further release of HIV related information is prohibited without specific authorization.

II. The purpose or need for the disclosure of information: ___ **Continued Medical Care** ___ **Legal Case** ___**Personal Use**
___ **other, please example:** _____

III. This authorization will expire on _____(Please indicate expiration date or specific event).

IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My written revocation must submitted to NJ Spine and Orthopedic Privacy Officer at 1200 US 22, Suite 14, Bridgewater, NJ 08807.

I understand that this practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I further understand that NJ Spine and Orthopedic may not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPPA privacy rule.

I understand I have the right to refuse this authorization and that the facility name above is release from all legal liability that may arise from the release or receipt of the information requested.

_____ _____ _____
(Signature of Patient of Legal Guardian) (Relationship to Patient) (Date Signed)

For Office Use Only: Authorization received/verified by: _____ **on** _____
Copy of Authorization from given to patient [ ] YES [ ] NO / Authorization fulfilled and information sent: _____