Hunterdon Health

2100 Wescott Drive, Flemington, NJ 08822

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE PRINT

Patient Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ Date of Birth: _____

Date of Service: _____

Specify Information to be Disclosed: _____

_____

_____

HIGHLY CONFIDENTIAL INFORMATION:

By signing my name next to a category of highly confidential information listed below, I specifically authorized the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to the Authorization:

- Behavioral Health Treatment Records/Substance Abuse Treatment Records: _____
  Privacy OfficeHealthInformationManagementServices,2100WescottDrive,Flemington,NJ08822,Phone:908-237-5478
  email: privacy.office@hunterdonhealth.org.FederalandStateStatutes:PsychiatricTreatment(NJSA10:37-6.79etseq.).Drug/Alcohol (42 CFR Part 2), HIV-related information (NJSA 26:5c to 25:5c-14), Genetic Information (NJSA 10:5-47 & 48), Venereal Disease (NJSA 26; 4-41), and Tuberculosis Information (NJAC 8:57-5.14).
- HIV/AIDS Related Information: _____
  (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Genetic Information: _____
- Venereal Disease Information: _____
- Tuberculosis Information: _____

RECIPIENT: NAME OF THE PERSON OR ORGANIZATION TO WHOM HUNTERDON HEALTH MAY DISCLOSE MY HEALTH INFORMATION.

Name: _____

Address: _____

_____

_____

PURPOSE: I authorize Hunterdon Health to use or disclose my health information during the term of this authorization for following specificpurpose(s):

_____

Fees (apply to photocopies provided to patients and their legally authorized representatives only; other fees may apply to other requestors): I understand that Hunterdon Medical Center is permitted under state and federal laws to charge me a fee for photocopies of my medical records and any applicable mailing/postage fees. I further understand that under New Jersey law, the fees are based on actual costs and may not exceed: **$1.00 per page or $100.00 per record (for the first 100 pages) and $0.25 per page thereafter up to a maximum of $200.00 per record.**

THIS AUTHORIZATION WILL REMAIN IN EFFECT: (Check One)

☐ UNTIL THE FOLLOWING EVENT OCCURS: _____
☐ 180 Days
☐ OTHER: _____

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I understand that once Hunterdon Health discloses my health information to the recipient, Hunterdon Health cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Hunterdon Health may, directly or indirectly, receive remuneration from a third part in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Hunterdon Health; except, however, if my treatment in the Hunterdon Health is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Hunterdon Health may refuse to treat me if I do not sign this Authorization.

If my treatment is related to my participation in a research study, I understand that treatment may be refused if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Hunterdon Health Privacy Officer at the address listed below. The revocation will be effective immediately upon Hunterdon Health receipt of my written notice, except that the revocation will not have any effect on any action taken by Hunterdon Health in reliance on this Authorization before it received my written notice of revocation.

I may contact Hunterdon Health by mail at:

Hunterdon Health
Health Information Management Services
2100 Wescott Drive
Flemington, N.J. 08822
Phone: 908-788-6380

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 the Hunterdon Health to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Relationship to Patient

Notice to Recipient of Information

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials under part 3 of this form, the following Notice applies to the information you have received pursuant to this information: This information has been disclosed to you from records protected by Federal confidentiality rules C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.