Hunterdon Family Medicine
at Delaware Valley

Hunterdon Healthcare
Your full circle of care.

Hunterdon Family Medicine at Delaware Valley
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Authorization for Disclosure of Protected Health Information

I,____________________________________hereby authorize __________________ to disclose information from the

records of____

/______________________________________

Patient's Name **Date of Birth**

Patient's Address: City: State: Zip

The information is to be:

Released from:
To:

OR

Released to:
From:

Purpose for request:

_____**For personal use only** (not transferring from practice)
_____**Transferring care to another local practice due to**_____________________________________
_____**Relocation out of area**
_____**Other**
_____**Insurance change-related (please indicate carrier**______________________________________

The following information is to be released: (Please check one)

______**Entire Medical Record.** Records specifically protected under State and Federal Confidentiality Statues. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and Federal law and prohibits any further disclosure without written consent of the persons to whom it pertains or otherwise provided by law.

______**Only specific portions of the medical record**. Itemize portions of record and time period of records to be released and indicate specific records that may not be released.

____
____

THIS AUTHORIZATION WILL REMAIN IN EFFECT: (Check One)

☐ UNTIL THE FOLOWING EVENT OCCURS: ____
☐ 180 Days
☐ OTHER: ____

Patient's Name:_________________________________/ DOB_________

I understand that once Hunterdon Healthcare discloses my health information to the recipient, Hunterdon Healthcare 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 Healthcare 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 Healthcare; except, however, if my treatment in the Hunterdon Healthcare is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Hunterdon Healthcare 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 Healthcare Privacy Officer at the address listed below. The revocation will be effective immediately upon Hunterdon Healthcare receipt of my written notice, except that the revocation will not have any effect on any action taken by Hunterdon Healthcare in reliance on this Authorization before it received my written notice of revocation.

I may contact Hunterdon Healthcare by mail at:

Hunterdon Healthcare
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 Healthcare to use or disclose my heath 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 @. 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.