Primary Care Partners
Affiliated with
Atlantic Health System

Authorization for RELEASE of Information

This form is to be used for releasing information to other physicians, facilities, schools, and outside agencies. In addition, this form is to be used when a patient wants their records to be transferred.

I do hereby consent to and authorize Primary Care Partners _____(Name of Care Center) to disclose to the facility/person(s) named, information from my medical records relating to my treatment. This release is to be **limited** to the specified reports within the **specified dates of treatment** I have indicated below. I understand that this consent shall operate as a complete release of liability to Primary Care Partners, the Care Center and to its employees for the release of information as specified below.

PURPOSE _____DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

TREATMENT DATES NEEDED: _____ TO _____ (specify month/year)

SPECIFIED REPORTS/EDUCATION INFORMATION: *(Check appropriate boxes)*

[ ] Abstract: face sheet, history & physical, discharge summary, all medical tests, operative section
[ ] All Medical Tests: labs, ECG, x-ray, operative section
[ ] Immunization/Vaccine Information only
[ ] Complete copy
[ ] HIV/AIDS treatment records *(if your information contains HIV/AIDS related information you must check this box)*
[ ] Certified Records
[ ] Drug/Alcohol treatment records Clinic
[ ] Psychiatric treatment records
[ ] Radiology Films
[ ] Genetic
[ ] Discharge Instructions
[ ] Medication Reconciliation
[ ] OTHER: _____

*A fee for copying medical records will be invoiced to the patient or legally authorized representative in accordance with N.J.A.C. § 8:43G- 15.3(d)(1)(2)(i)-(ii), HIPAA Privacy Standard § 164.524 (c) (4).When payment is received the records will be released. ** For continuing care purposes, there will not be a charge for records sent directly to a physician or facility. ** Processing time will vary due to the status of the record.*

RELEASED TO:

Name: _____ Phone: _____
Address: _____Zip: _____
Special Instructions: _____
To be: [ ] Picked up [ ] Mailed [ ] Other _____

Unless otherwise revoked by me, this Authorization is **valid for 6 months** from the date above. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this Authorization. I have the right to refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Primary Care Partners to use or disclose my health information in the manner described above.

Patient Signature _____Patient Printed Name:_____ Witness _____

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

_____ _____ _____
Signature of authorized Legal Guardian, Health Care Agent, or Relationship other authorized Personal Representative | Date | Signature of Witness