ROWAN UNIVERSITY
School of Osteopathic Medicine

ROWAN MEDICINE
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

SECTION 1: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Telephone No.: _____ Social Security# (last 4 digits only): _____

SECTION 2: RELEASE RECORDS TO:

I hereby consent and authorize Rowan Medicine to release information from my medical records to:

_____
Name of Provider/Insurance Company/Other Agency, Person, or Self

_____
Street Address City/State/Zip Code

Phone Number: _____ Fax Number: _____

For the purpose of: ___ Continuation of Care ___ Social Security/Disability ___ Insurance Purposes ___ Caregiver

___ Legal Purposes ___ Personal Access ___ Other: _____

INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY THE FEDERAL HIPAA PRIVACY RULE OR OTHER CONFIDENTIALITY LAWS.

SECTION 3: SPECIFIC INFORMATION TO BE RELEASED:

The information to be released will cover the time period from _____ to _____.

SPECIFIC INFORMATION TO RELEASE:

___ Abstract*	___ Physician Orders	___Office Notes/Visit Notes	___ Imaging Films (X-rays, Scans, CD)
___ Pathology Reports	___ Photographs	___ Immunizations	___ Consultation Reports
___ Itemized Bills	___ Disability/FMLA Forms	___ Laboratory Results	___ Medication List
___ Imaging Reports	___ Problem List	___ History & Physical Exams	___ EKG, EEG, Stress Tests

___ **Entire Record** (includes records from other entities)

___ **EXCEPTION:** I do not give my permission to release (specify): _____

* An abstract is a composite of the medical record that is most helpful to patients and contains the information that is sent to providers for continuity of care. The abstract contains the history and physical, consultation reports, all operations, diagnostic and laboratory results.

SECTION 4: SPECIAL AUTHORIZATIONS FOR MENTAL HEALTH, DRUG AND ALCOHOL, SEXUALLY TRANSMITTED OR COMMUNICABLE DISEASES AND HIV RECORDS:

ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION

I understand that my medical records may contain "protected information" related to the following categories. This protected information is being disclosed from records whose confidentiality is specifically protected by federal and New Jersey state laws. My signature below these items acknowledges my awareness and my authorization to release such "protected information" in my medical records.

Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician/provider.

_____
Patient Signature

Psychiatric or psychological information, if psychiatric or psychological treatment was given by my provider. I understand that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.

_____
Patient Signature

HIV related information for individuals 12 years or older, if HIV-related tests were ordered by my physician/provider (NJAC 13:35-6.5(3) (c)).

_____
Patient Signature

Sexually transmitted or communicable diseases, if related tests or treatment were given by my provider.

_____
Patient Signature

Medical records that contain DNA test results or other genetic information require additional protections under New Jersey state law. If you believe that your records contain such information, please sign below and you will be contacted for separate, specific consent prior to release of this information.

_____
Patient Signature

SECTION 5: AUTHORIZATION SIGNATURES:

I hereby authorize Rowan Medicine to disclose my protected health information as described above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my revocation to Rowan Medicine. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, this authorization will expire in one (1) year.

I understand that authorizing the disclosure of my protected health information is voluntary and that I can refuse to the sign the form if I do not wish this request processed. I understand that my refusal to sign this form in no way affects my treatment, payment, enrollment in health plans or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in 45 CFR 164.524. I understand that the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
If signed by Legal Representative, Relationship to Patient