ROWAN UNIVERSITY
School of Osteopathic Medicine

AUTHORIZATION AND REQUEST TO RELEASE INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____

Phone#:_____ Social Security#:_____

I hereby authorize: _____
(Name of physician/department disclosing information)

to disclose to: _____
(Person to whom disclosure is being made)

Address: _____

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of my medical records to the following extent: _____

_____

for: _____
(Purpose of disclosure)

I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV), that my signing this document authorizes Rowan SOM to release that information. I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE_____.

[ ] A check here indicates that I believe my medical records may contain DNA test results or other genetic information. New Jersey law specifically protects such information, and I will be contacted for separate, specific consent prior to release of this information.

This consent may be revoked at any time by writing to RowanSOM. I understand that revocation does not apply to information that has already been released in response to this authorization. If not previously revoked, this release will terminate upon _____. If I fail to specify an expiration date, event or condition, this authorization will expire in **one year.**

I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to re-disclosure by the recipient and may not be protected by privacy and confidentiality laws. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. Rowan SOM will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization. I may inspect or copy the information to be used or disclosed.

I authorize the use of a copy of this signed form for the disclosure of the information described above.

Signature: _____ Date:_____

Printed Name: _____