RWJBarnabas HEALTH

REQUEST FOR COPY OF MEDICAL RECORD &
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO OTHERS

DROP OFF	OR MAIL	OR FAX
The completed form to your provider's office where you received care.	**The completed form to our central office:** **BHMG Medical Records** **85 S. Jefferson St., Lower Level** **Orange, NJ 07050**	**The completed request to:** **973-673-1577**

If a copy fee is applicable, it will be applied according to New Jersey Regulations. Should you have any questions, please leave a message at **973-673-1578**, and we will return your call within 2 business days.

PATIENT Last Name_____**First** _____**Middle**_____

Maiden or Other Name _____ **DOB**_____

ADDRESS _____

CITY _____ **STATE** _____**ZIP** _____

Home Phone_____ Cell Phone_____

Physician/Practice Name and Location:_____

For the following dates of service: From:_____To:_____

INFORMATION TO BE DISCLOSED:

❑ Complete Record ❑ Labs, X-rays & Tests ❑ Immunization Record

❑ Abstract (last 3-6 months Lab Tests, past year Pathology/Radiology, growth charts, ECGs/ EKGs, and other special tests)

❑ Other:_____

This authorization is limited to treatment received at the following Barnabas Health Medical Group

I hereby authorize the Barnabas Health Medical Group to disclose my health information to:

Name/Company:_____

❑ **Secure electronic delivery to email address:** _____

❑ **Paper copies sent via mailing address**:_____

_____

The information to be disclosed to and used by the above is for the following purpose:

❑ **PERSONAL USE BY PATIENT** ❑ **CONTINUING CARE** ❑ **ATTORNEY/LEGAL** ❑ **OTHER:**_____

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I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated 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 written revocation to the Barnabas Health Medical Group address listed above. I understand that this revocation will not apply to the extent that the practice has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:_____

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Barnabas Health Medical Group at **973-673-1577**.

PATIENT SIGNATURE:_____ DATE: _____

If legal representative, please sign below, state relationship, authority to do so and **attach the document of authority.**

SIGNATURE - LEGAL REPRESENTATIVE _____Date: _____

PRINT NAME - LEGAL REPRESENTATIVE_____Relationship:_____