PATIENT IDENTIFIER

Bergen New Bridge Medical Center • Paramus, New Jersey 07652
Phone: 201.225.6799 ▪ Fax: 201.967.4138
Email: HealthInfo@newbridgehealth.org

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

A

Patient Name: ______________________________ MR#: ______________________________
DOB: ______________________________
RELEASE INFORMATION TO: ______________________________

Name: ______________________________
Address: ______________________ City, State: ______________ Zip: ______________
Phone#: ____________ Fax#: ________________ Email: ______________________
Purpose of Disclosure: ☐ Continuation of Care ☐ Legal ☐ Personal Use ☐ Other: ______________________

☐ ***I authorize Bergen New Bridge Medical Center*** **to obtain records from**: ______________________

B

INFORMATION TO BE RELEASED: ☐ Inpatient ☐ ER ☐ SDS ☐ Outpatient/Clinic
Treatment Dates Needed: ______________________________
☐ Abstract: It includes a history and a physical, test results, consultations, operative reports, and discharge summary, if applicable.

☐ Physical Examination / Consultations
☐ Progress Notes
☐ Operative Report/Pathology
☐ Lab / Test Results / X-Rays / Scans
☐ Radiology Images
☐ Psychological Testing / Evaluation
☐ Discharge Summary/PDI-Discharge Instructions (Discharge Packet)
☐ Entire Record
☐ Other: ______________________________

C

PLEASE INITIAL ALL THAT APPLY: Release of Specific Information - By initialing here, I authorize Bergen New Bridge Medical Center to release information regarding:

Alcohol Use/Abuse: ________ Substance Use/Abuse: ________ Psychotherapy Notes: ________
Pregnancy: ________ STDs: ________ HIV/AIDS: ________ Sexual Assault: ________

D

ACKNOWLEDGEMENTS

* I understand that this authorization expires one year from the date of the signature below or sooner if I provide a written revocation to Bergen New Bridge Medical Center
* I understand that I may revoke this authorization at anytime in writing, but if I do, it will not have any effect on any actions take prior to Bergen New Bridge Medical Center receiving the revocation.
* I understand that I may refuse to sign this authorization and that it is strictly voluntary.
* Any information disclosed which is protected under Federal confidentiality rules (42 CFR Part 2) will be treated as specified by such rules.
* I understand that information disclosed under this authorization may be re-disclosed by the recipient and in case of such re-disclosure, the information may not be protected by federal privacy laws or regulations.
* I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee. I understand that Bergen New Bridge Medical Center may deny this request under limited circumstances and that Bergen New Bridge Medical Center will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request.
* **I understand the risks related to confidentiality inherent in the use of technology (i.e., information may not reach the person for whom it is intended, or may reach someone else for whom it was not intended, may be stored or forwarded without authorization). Despite this risk, I request that my records be transmitted as indicated:**
  ☐ Mail ☐ Fax ☐ Email ☐ Paper ☐ Electronic CD

E

Authorization Signature: I have read the above and authorize Bergen New Bridge Medical Center to disclose the protected health information as stated.

______________________________ Date: __________
Signature of Patient (Signature required for all patients age 13 and older)

Patient's Representative:

Print Name: ______________________ Signature: ______________________

Date: ______________ Relationship to Patient: ______________________

Witness:

Print Name: ______________________ Signature: ______________________

Date: ______________ Relationship to Patient: ______________________

NOTE to Recipient of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal and State law. Federal and State regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Anyone who receives information covered by these regulations, whether obtained legally or not, is prohibited from using that information for any criminal or civil investigation, or prosecution of the patient. (Federal Regulation 42CFR part 2; N.J.S.A. 26:5C-11) (N.J.A.C. 10:37-6.79(a) 3).

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DIRECTIONS FOR COMPLETING AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Note: Release of information will occur after hospital discharge

Section A

- Provide the patient's name, date of birth, email address and phone number.
- Provide the name, address, phone number, fax number and email address of the recipient.
- The recipient is whoever is going to receive the records.
- Identify the purpose (reason) you are requesting copies of medical records by checking the appropriate box.
- If the recipient is different than the patient, check the box that authorizes Bergen New Bridge to obtain records from a recipient other than the patient and provide the recipient's name.

Section B

- Check the appropriate box for the type of record to be released
- Indicate the dates of service. If you do not know the exact dates, indicate the year.
- Indicate what information you are requesting by checking the box that identifies the information that you need or write in the information that you need in the space provided.

Section C

- If you would like sensitive information released as part of your medical record, place your initials next to the applicable information.
- A minor (13 years and older) is considered emancipated if any of the below information is applicable.

Section D

- Read Acknowledgments
- Check the method of delivery that you would like your records transmitted: mail, fax, email, paper, electronic CD. By checking this box, you acknowledge that you understand the risks related to confidentiality inherent in the use of technology and despite this risk, you request that your records be transmitted as indicated.

Section E

- The patient must sign and date the form, by signing this form you acknowledge that you have read all of the above information and that you authorize Bergen New Bridge Medical Center to disclose the protected health information as stated.
- If the patient has a legal representative, who is signing, a copy of the legal paperwork must be submitted with this request and the relationship to the patient must be indicated in the space provided on the form.