



**HUNTERDON
MEDICAL
CENTER**
2100 Wescott Drive
Flemington, NJ 08822

**AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Date requested: _____ Date needed: _____

I, _____ hereby authorize _____
Name of patient/participant Health Care Facility

to disclose information from the records of:

Patient's Name Birth Date Patient Phone #

The information is to be disclosed to:

Name: _____

Address: _____

Phone #: _____

for the specific purposes of: _____

The following information is to be released (itemize portions of record and time period): _____

I understand that the information to be disclosed may include diagnosis, prognosis and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and Federal law and prohibits any further disclosure without written consent of the persons to whom it pertains or otherwise provided by law.

Having read the above information, I release Hunterdon Healthcare System, its employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of information set forth above relating to my protected Health Information.

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to Hunterdon Healthcare System's Privacy Office at the address listed below. The revocation will be effective immediately upon Hunterdon Healthcare System's receipt of the written notice. I understand that revocation may not be made if the action has already been acted upon based on prior authorization.

This authorization is valid for (check one) from the date of signature:

180 days 120 days for Behavioral Health patients

Patient's Signature Date of Signature

Witness Signature of Responsible Party

If patient is unable to sign, complete the following:

Patient is a minor ____ years of age.

Patient is unable to sign because: _____

Privacy Office Health Information Management Services, 2100 Wescott Drive, Flemington, NJ 08822 Phone: 908-237-5478 email: privacy.office@hunterdonhealthcare.org
Federal and State Statutes: Psychiatric Treatment (NJSA 10:37-6.79 et seq.), Drug/Alcohol (42 CFR Part 2), HIV-related Information (NJSA 26:5c to 26:5c-14), Genetic Information (NJSA 10:5-47 & 48), Venereal Disease (NJSA 26: 4-41), and Tuberculosis information (NJAC 8:57-5.14).

