

## Authorization to Release Protected Health Information

### Section 1: Patient Information

PATIENT NAME	SOCIAL SECURITY NO. LAST 4 DIGITS ONLY	DATE OF BIRTH
PATIENT ADDRESS	CITY	STATE
	ZIP CODE	TELEPHONE NO.

### Section 2: Location(s) of Care

- Jefferson Cherry Hill Hospital
  Jefferson Stratford Hospital
  Jefferson Washington Township Hospital  
 Other (if other location is selected – provide the specific location, address or physician practice/name where you received care):


### Section 3: Release Records To:

**I hereby consent to and authorize the above entities to release information from my medical record to:**

Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self:

Address:

Fax#:

For the Purpose of:  Continuation of Care  Social Security/Disability  Insurance Purposes  Lay 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 4: Specific Information to Be Released

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

#### SPECIFIC INFORMATION TO RELEASE:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abstract*                | <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Physician Orders  |
| <input type="checkbox"/> Office Notes/Visit Notes | <input type="checkbox"/> Operations Report      | <input type="checkbox"/> Imaging Films (X-rays, Scans, CD)                             |
| <input type="checkbox"/> Discharge Instructions   | <input type="checkbox"/> Pathology Reports      | <input type="checkbox"/> Photographs   |
| <input type="checkbox"/> Immunizations            | <input type="checkbox"/> Consultation Reports   | <input type="checkbox"/> Itemized Bills  |
| <input type="checkbox"/> Disability/FMLA Form     | <input type="checkbox"/> Laboratory Results     | <input type="checkbox"/> Catheterization Lab   |
| <input type="checkbox"/> Medication List          | <input type="checkbox"/> Imaging Reports        | <input type="checkbox"/> <b>Entire Record</b> (includes records from other facilities) |
| <input type="checkbox"/> Problem List             | <input type="checkbox"/> EKG, EEG, Stress Tests |  |
| <input type="checkbox"/> Emergency Room Record    |   |  |
| <input type="checkbox"/> History & Physical Exams |   |  |
| <input type="checkbox"/> Other (specify) _____    |   |  |

**Exception:** I do not give permission to release (specify): \_\_\_\_\_

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



# Instructions for Completing the Authorization for Release of Protected Health Information Form

1. Please complete all sections of the Authorization for Release of Protected Health Information Form.
2. The patient or legally authorized representative must sign and date the form.

Jefferson may require proof of representation if the form is signed by a personal representative. For minors (under 18 years), a parent or legal guardian must sign, with the following exceptions:

- emancipated minors may sign this form (a patient who has left the parental household, supports him/herself financially, and lives independently);
- emancipated minor includes a minor who has been married, has entered military service, has a child or is pregnant, or has previously been declared by a court or administrative agency to be emancipated may also sign this form;
- minors may authorize release of PHI related to pregnancy, sexually transmitted diseases, or substance abuse treatment; and
- minors 14 years or older may authorize release of their mental health treatment records, provided the patient understands the nature of the information and the reason for use or disclosure.

3. Please mail the completed form to:

<p style="text-align: center;"><b>Jefferson Cherry Hill Hospital Health Information Management 2201 Chapel Avenue West Cherry Hill, NJ 08002</b></p> <p style="text-align: center;">Phone: (856) 406-4850 Fax: (856) 488-3578</p> <p style="text-align: center;">Hours of Operation: Monday – Friday 8:00 a.m. – 4:30 p.m.</p>	<p style="text-align: center;"><b>Jefferson Health Stratford Hospital Health Information Management 18 E. Laurel Road Stratford, NJ 08084</b></p> <p style="text-align: center;">Phone: (856) 406-4850 Fax: (856) 488-3578</p> <p style="text-align: center;">Hours of Operation: Monday – Friday 8:00 a.m. – 4:30 p.m.</p>	<p style="text-align: center;"><b>Jefferson Health Washington Township Health Information Management 435 Hurffville – Cross Keys Road Turnersville, NJ 08012</b></p> <p style="text-align: center;">Phone: (856) 406-4850 Fax: (856) 488-3578</p> <p style="text-align: center;">Hours of Operation: Monday – Friday 8:00 a.m. – 4:30 p.m.</p>
<p style="text-align: center;"><b>Jefferson Health Care Center 535 Egg Harbor Road Sewell, NJ 08080</b></p> <p style="text-align: center;">Phone: (856) 557-0100 Fax: (856) 589-2154 Monday - Friday 8:00 a.m.-4 p.m.</p>	<p>Other: _____</p> <p>_____</p>	

#### 4. Please Note:

Jefferson will charge for copying records in accordance with State and Federal Laws. [§ 8:43G-15.3 Medical record patient services](#)

Jefferson will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.

**ANY COPIES OF MEDICAL RECORDS THAT ARE SENT VIA FED-EX, UPS, ETC. WILL REQUIRE A SIGNATURE UPON DELIVERY.**

If the person or entity receiving the health information is not a health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

Jefferson may deny this request under limited circumstances as provided for under federal or state law. Jefferson will notify you if it denies your request to access or obtain a copy of the requested information. If Jefferson denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.