CarePoint Health
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Form ID: ROI
AUTHORIZATION FOR RELEASE OF INFORMATION OF PROTECTED HEALTH INFORMATION (PHI)
Reorder #: 90015 (REV. 8/16-A)

PATIENT ID LABEL

❑ Bayonne Medical Center ❑ Christ Hospital ❑ Hoboken University Medical Center ❑ Other: _____ ❑ CarePoint Physician Practice: _____

All portions of this form **must** be completed to constitute a valid authorization of release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

I HEREBY AUTHORIZE USE/DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS FOLLOWS:

1. Patient Information: (Please print)

Last Name: _____ First Name: _____ Middle Initial: _____ MR #: _____

Date of Birth: _____ Phone Number: (_____) _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

2. Release of Information is to (I authorize the use and disclosure of health information about me as described below):

Name/Organization: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

3. Health Information that may be used/disclosed is limited to the following (check all that apply):

❑ Progress Notes ❑ Consultation(s) ❑ X-ray Report(s) ❑ Billing Records
❑ Emergency Room Record ❑ Lab(s) ❑ EKG/EEG ❑ Imaging/X-ray Film(s)
❑ Discharge Summary ❑ Pathology Report ❑ Fetal Heart Monitor Strips ❑ Other (specify): _____
❑ History & Physical ❑ Operative/Procedure Note(s) ❑ Entire Medical Record _____

4. Health Information that may be used/disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____

From (date): _____ To (date): _____ Account Number: _____

5. Health information to be released to the above named agency/individual is to be used for the following purpose(s):

❑ Treatment/Consultation ❑ Research ❑ Billing or Claims Payment ❑ Legal
❑ At Request of Patient ❑ Marketing ❑ At Request of Employer ❑ Other (specify): _____

Policy for Restriction of Disclosure CPCOM 031 Any prior restriction of disclosure on file? ❑ Yes ❑ No Date: _____

I hereby give special authorization to release the following information excluding Psychotherapy notes (check all that apply):

❑ AIDS/HIV ❑ Alcohol Abuse ❑ Drug Abuse ❑ Mental Health ❑ DNA

Signature: _____ Date: _____ Time: _____

Personal Representative Signature (if applicable): _____

Description of authority to act on behalf of the patient: _____

_____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the facility, its agents and employees for any and all liabilities, responsibilities, damages and claims which might arise from this authorized release of the information that was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility ❑ **Yes** ❑ **No** ***if applicable,*** I agree to the release of my medical or billing records containing the sensitive information listed above.

Protected Health Information used or disclosure pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire **90** days after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event, I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Expiration Date of Event: _____

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature:	Date:	Time:
Relationship to Patient/Authority to Act on Patient's Behalf:		
Witness's Signature:	Date:	Time:

❑ Signature validated against government issued ID or signature in medical record. There may be a charge for copying medical records.
❑ Electronic copy requested.

Interpreter, if Utilized:	Interpreter Name: ❑ Approved Translation Service ❑ Trained Staff Member	Interpreter ID#:	Language Accessed:

***A copy of this authorization must be given to the individual**