



**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ PATIENT # \_\_\_\_\_

Address \_\_\_\_\_

Telephone(s) \_\_\_\_\_

I hereby authorize: \_\_\_\_\_

to disclose my health information to Garden State Urology

PLEASE FAX THE INFORMATION OR EXPRESS MAIL THE FILMS OR SLIDES (IF REQUESTED) TO OUR OFFICE.

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

This authorization is limited to the following dates of treatment: FROM \_\_\_\_\_ TO \_\_\_\_\_

Information to be disclosed:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> COMPLETE RECORD     | <input type="checkbox"/> PATHOLOGY RECORDS | <input type="checkbox"/> LAB, EKG, ETC.      |
| <input type="checkbox"/> BILLING INFORMATION | <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> NURSES NOTES        |
| <input type="checkbox"/> HISTORY & PHYSICAL  | <input type="checkbox"/> PORTAL FILMS      | <input type="checkbox"/> SOCIAL WORKER NOTES |
| <input type="checkbox"/> SUMMARY/FOLLOW UP   | <input type="checkbox"/> TREATMENT SUMMARY | <input type="checkbox"/> OTHER: _____        |

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 Health Information management Department. I understand that this revocation will not apply to the extent that Garden State Urology has already taken action in reliance on this authorization. This authorization will automatically expire six (6) months from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the event or condition: \_\_\_\_\_.

I understand that authorizing the disclosure of this health information is 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 information carries with it the potential for an unauthorized 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 privacy Officer at 973-240-3000.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If legal representative, sign below and state relationship and authority to do so and attach the Document of Authority.

Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Address: <> Phone: <> Fax: