Authorization to Release Patient Information

Deborah® Specialty Physicians

This request will not be processed unless all areas are completed.

Fees may apply to record requests and will be identified before record requests are fulfilled.

Patient Name _____

Address _____

Date of Birth _____

I, hereby authorize Deborah Specialty Physicians to release my health information described below:

To _____

Address _____

Phone _____ Date needed by _____

Delivery Options: ❑ Mail ❑ Pick-up ❑ Fax _____

❑ CD ❑ Encrypted email *(subject to limitations)*

Purpose of disclosure: Please explain or indicate "at the request of the individual" if for self:

_____

_____

Deborah Specialty Physicians location/physician that records are requested from:

❑ Browns Mills
❑ Galloway
❑ Lawrenceville
❑ Manahawkin
❑ Mount Laurel
❑ Toms River
❑ Toms River/Pulmonary Medicine
❑ Toms River/Primary Care Physician
❑ Whiting

I request the following information be released (check off each one requested):

Note: only a medical summary of your visit will be released unless specific tests are requested.

❑ Entire record _____

❑ Portions of the record (specify documents and/or dates of treatment) _____

_____

❑ Discharge Summary/Date(s) _____

❑ Laboratory Report/Date(s) _____

❑ Outpatient Record(s)/Date(s) _____

❑ Operative Report(s)/Date(s) _____

❑ Pathology Reports/Date(s) _____

❑ Radiology Report(s) and Films/Dates(s) _____

❑ Echocardiogram/Date(s) _____

❑ Cardiac Cath Report and Films/Date(s) _____

❑ Other (please list) _____

_____

_____

continued...

AUTHORIZATION

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this authorization, at any time prior to Deborah Specialty Physicians compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating my right to revoke this authorization and a description of how I may revoke this authorization is set forth in Deborah Specialty Physicians Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to: **Deborah Specialty Physicians, Attn: Medical Records Dept., 200 Trenton Road, Browns Mills, NJ 08015.**

I understand that I am not required to sign this authorization and that Deborah Specialty Physicians may not condition treatment (payment, enrollment in a health plan or eligibility for benefits) on my execution of this authorization, unless Deborah Specialty Physicians is providing health care solely for the purpose of creating protected health information that will be disclosed to a third party (such as a life insurance company, school or employer) in which case it may require me to sign this authorization before health care is provided.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the Recipient listed on page 1, in that case, will no longer be protected by HIPAA, except that restrictions apply to use and redisclosure of records from a federal drug and alcohol Part 2 Program, if any, for civil, criminal, administrative and legislative proceedings against me.

Additionally, and in accordance with State mandated regulation, hereby consent to release/disclosure to the recipient named on page 1, from my medical record relating to my identity, diagnosis, prognosis, medications, and treatment and/or condition related to: psychological or psychiatric impairment, drug abuse and/or alcohol abuse (including records from a federal drug and alcohol Part 2 Program), reproductive health services information, sickle cell anemia, tuberculosis, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and/or human immunodeficiency virus (HIV), and genetic information, including genetic testing.

This authorization expires upon completion of the Purpose set forth on page 1. I acknowledge that I have read and understand this authorization and have had the opportunity to ask any questions and have them answered. **I understand I am authorizing Deborah Specialty Physicians to send my medical records described herein, to the recipient as described on page 1.**

Signature of Patient/Representative:_____

Print Name:_____ Date: _____

Description of Patient Representative's Authority:_____

Please submit this form via fax to the applicable office below.

Browns Mills: 856-206-9017

Galloway: 609-748-7574

Lawrenceville: 609-512-7151

Manahawkin: 609-597-8382

Mount Laurel: 856-206-9017

Toms River: 732-577-5016

Toms River/Pulmonary Medicine: 732-818-0210

Toms River/Primary Care Physician: 732-281-0534

Whiting: 848-258-7922

2/24, Media FM; Source, DSP, Karen Evans