CentraState Healthcare System®
ATLANTIC HEALTH SYSTEM PARTNER

DT2201

AUTHORIZATION FOR RELEASE OF INFORMATION

MRN/HAR: _____

Request ID: _____

SECTION A: **Patient Information:** Daytime Phone Number: _____

Patient Name: _____ Date of Birth: _____

Patient's Address: _____

I hereby authorize and request CentraState Healthcare System to release information related to treatment at (check one):

☐ CentraState Medical Center

☐ Other (specify): _____

Information to be released to (receiver): ☐ Check if the same as patient

Recipient Name/Facility/Organization: _____

Complete Address: _____

Phone Number: _____ Attention to: _____

Purpose of Release: ☐ Physician ☐ Facility ☐ Personal Use ☐ Legal ☐ Other: _____

Request Delivery Type *(if blank, a paper copy will be provided)*: ☐ Paper Copy ☐ Electronic Media (CD) ☐ MyChart

☐ Encrypted Email*: _____ ☐ Fax Number: _____ ☐ Pick-Up

In the event the facility is unable to accommodate an electronic delivery as requested, an alternate delivery will be provided (e.g. paper). ☐ Postal Mail

***NOTE:** Choosing encrypted email delivery involves some level of risk. We are not responsible for unauthorized access to the PHI contained in this format, or any risks (e.g. virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.*

SECTION B: ☐ **I hereby authorize CentraState Healthcare System to obtain medical records from:**

Name: _____ Fax Number: _____

Address: _____ Dates of Service: _____

SECTION C: **Description of Information to be Released/Obtained:** **Dates of Service:** _____

☐ Abstract (most common) face sheet, discharge summary, history & physical, consult, test results, operative reports, ED

☐ Admission/Face Sheet	☐ EEG/Sleep Reports	☐ Mental Health Consult/Eval	☐ _____
☐ Complete Medical Record	☐ History & Physical	☐ Operative Report	☐ _____
☐ Consultation Report	☐ Immunization Record	☐ Pathology Report	☐ _____
☐ Discharge Summary	☐ Laboratory Report	☐ Pathology Slides/Specimen	
☐ Cardiology/Radiology Images	☐ Medication Record	☐ Radiology Report	

Special Instructions: _____

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

_____ HIV/AIDS Treatment Records _____ Psychiatric Treatment Records _____ Genetic Testing/Treatment Records

_____ Treatment for Alcohol and/or Drug Abuse _____ Sexually Transmitted Diseases Testing _____ Reproductive Healthcare Services

SECTION D: **Patient Authorization: I understand that:**

1. Unless revoked by me, this authorization is valid for 6 months from the date above. Revocations must be made in writing. Mail revocation to the address on the back of this form. Revocation may not be made if action has already been taken in reliance on this authorization.
2. I understand the terms of this authorization are governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, it may be amended from time to time.
3. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits.
4. CentraState Healthcare System cannot guarantee that the recipient identified will not re-disclose my health information to a third party.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.

Patient/Authorized Representative or Guardian: _____ Date: _____ Time: _____
(signature of minor at age or above 12 is required for certain information)

If signed by legal authorized representative, specify relationship: _____

CentraState Healthcare System Personnel Signature: _____ Date: _____ Time: _____

DIRECTIONS FOR COMPLETING THE AUTHORIZATION TO RELEASE INFORMATION
*NOTE: Release of Information will occur after hospital discharge

HIPAA regulations allow a healthcare entity up to 30 days to process copy requests for medical records. We generally complete requests prior to the allotted time permitted, but due to the possibility for a heavy volume of requests received, we cannot guarantee a specific date prior to the 30 days.

SECTION A:

- Fill in today's date.
- Provide the patient's name, date of birth, medical record number if known, patient address and daytime phone number.
- Select the CentraState Healthcare System hospital or physician practice where you were treated.
- Provide the name and address of the recipient. The recipient is whoever is going to receive the records. If the recipient's name is the same as the patient, check the box and move onto the next section.
- Identify the purpose (reason) you are requesting copies of medical records by checking the appropriate box.
- Next, check the method of delivery: paper copy, electronic copy (CD), fax, encrypted email, MyChart.
- If by mail, provide the email address clearly and legibility and read the risk notice under Request Delivery Type section.
- If by fax, be sure to write in the correct fax number legibly, including area code.

SECTION B:

- If a CentraState Healthcare System facility or physician has asked that they obtain your medical records from another facility, check this box and fill out the facility, physician or organization name and complete address.
- Please indicate the dates of service. If you do not know the exact dates, please enter the year.

SECTION C:

- Indicate what information you are requesting. Most common is the Abstract, which contains the face sheet, discharge summary, history and physical, ER report, consultation, all tests such as lab, radiology, and operative reports from physicians.
- Otherwise, check the box identifying the information you need or write in the specific information you need.
- Place your initials next to HIV/AIDS, Drug/Alcohol, Genetic, Sexual Disease, or Psychiatric, if you would like this sensitive information released as part of your medical record. This requires additional acknowledgment by the patient or their legal authorized representative.

SECTION D:

- The patient must sign and date the form.
- If the patient has a legally authorized representative, please sign and date the form. A spouse is not a legal representative unless they have legal power of attorney or healthcare surrogacy paperwork. A copy of the legal paperwork must be submitted with this request.
- Patients over the age of 18 years of age must request their own records, unless otherwise legally unable to sign this authorization. If legally unable to sign,documentation must be provided such as guardianship paperwork or healthcare proxy.
- Minor patients have the right to consent to care and therefore, the minor patient may also control the release of their medical record information related to their treatment. Minors age 12-17 must authorize the release of certain information concerning the minor such as HIV/AIDS, Drug Alcohol, Psychiatric, Sexual Disease, Pregnancy and Abortion Services.

There may be a copy fee for the information you requested.

Patient fee schedule:

How would you like to receive your copy?	***How Medical Records are Maintained***	***Reasonable, Cost-Based Fee***
Paper or Electronic (email CD/DVD, MyChart)	Electronically	First copy free of charge; Subsequent copies $6.50 per copy
Paper or Electronic	Paper	Flat fee of $6.50 (inclusive of labor, supplies and postage)

If the hospital determines that your records or information are protected by federal or state law concerning confidentiality of alcohol or drug abuse records, diagnosis and treatment of HIV/AIDS or HIV related illness, the following note will be attached to the release: *"NOTE to Recipient of Information: This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CFR part 2; N.J.S.A. 26:5C-1 et. seq.) The Federal or State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2 or N.J.S.A. 25:5C-1 et. seq. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal or State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."* This authorization shall not be used to disclose protected health information for marketing purposes and/or the sale of protected health information.

CentraState Healthcare System Contact Information
All Major Holidays Observed

CentraState Medical Center
901 West Main Street
Freehold, NJ 07728
phone: 732.294.2750 fax: 732.294.2535
email: requestedrecords@centrastate.com
Hours of Operation: Monday-Friday 8:30am-4:30pm

NOT PART OF THE PERMANENT MEDICAL RECORD