ST. FRANCIS MEDICAL CENTER, TRENTON NEW JERSEY
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Medical Record Number :

Patient Name:_____ Date of Birth_____ Phone #: _____

Home Address: _____

1. I authorize St. Francis Medical Center to use or disclose the above named individual's health information as described below.

2. Discharge Date/Dates of Service:

3. The type of information to be used or disclosed is as follows:

☐ Minor Surgery Record	☐ X-Ray Films	☐ ER Record
☐ Discharge Summary	☐ X-Ray Reports	☐ Clinic Record
☐ History and Physical	☐ Progress Notes	☐ Outpatient Record (specify) _____
☐ Consultation Reports	☐ Operative Report(s)	☐ Entire Medical Record
☐ Lab Reports	☐ Pathology Report(s)	☐ Other(specify)_____

4. **RELEASE INFORMATION TO:** ☐ Myself (the patient or representative) ☐ Organization/Individual below:

Name of Organization/Individual:_____

Address of Organization/Individual_____

☐ Please mail to above address ☐ Please prepare records for pick-up on this date:

5. **SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE:** By signing my initials next to the specific category of highly confidential information, I am authorizing St. Francis Medical Center to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above

_____ HIV/AIDS Related Information _____ Mental Health/Psychiatric Information _____ Drug and Alcohol Information

6. **PURPOSE OF RELEASE**: I authorize St. Francis Medical Center to release my health information for the following specific purpose:_____

7. I understand 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 the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days. A copy of this authorization (including a facsimile copy, photocopy or email) may be used with the same effectiveness as the original

8. 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. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that St. Francis Medical Center cannot make me sign this authorization form as a condition to receive treatment from the Hospital except when the hospital provides me with research related treatment or when the Hospital provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at (609) 599-5203.

9. I understand that I may be charged a fee for copies of my medical records and any applicable mailing/postage fees.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness