Authorization for Health Information Disclosure

This form complies with the HIPAA Privacy Rule

Patient Information

(please print)

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

I hereby authorize: _____

(Name of physician's/medical practice disclosing information)

Phone: _____ Fax: _____

(Please provide the contact numbers for the physician's office so we may fax the request to them)

Requestor/Recipient Information

Please disclose the following protected health information to: Rowan-SOM NeuroMusculoskeletal Institute

42 East Laurel Rd., Suite 1700, Stratford, NJ 08084. Ph: 856-566-7010 **Fax: 856-566-6880**

Please indicate the information or types of information to be disclosed: _____

_____

_____

Specify dates (or ranges) if applicable: _____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make the disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, or genetics.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITAIL: DO NOT RELEASE_____.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Description of Representative's Authority (witness signature required) Signature of Witness