Hackensack Meridian
Pascack Valley Medical Center

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

HEALTH INFORMATION
FAX: (201) 781-1111

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #: _____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

- ☐ Entire Medical Record
- ☐ History and physical exam
- ☐ Laboratory test results/reports
- ☐ Operative report
- ☐ Pathology report
- ☐ Consultation reports
- ☐ X-ray reports
- ☐ Emergency room record
- ☐ Discharge summary
- ☐ Progress notes
- ☐ X-ray films/images
- ☐ Itemized bill
- ☐ Other, (specify) _____

Purpose of Request

☐ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment
☐ The following marketing purposes: _____
☐ Other, (specify) _____

Payments to Facility

This marketing activity involves direct or indirect compensation/payment from a third party to Hackensack UMC at PV for this use of protected health information. **Check One**: ☐ Yes ☐ No _____ Initials

Person Authorized to Receive Information

Name: _____

Address: _____

_____

Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ☐ Yes ☐ No _____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ***Check One:*** ☐ Yes ☐ No _____ Initials

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 250 Old Hook Road, Westwood, NJ 07675. Unless revoked, this authorization will expire on the following date or event_____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Hackensack UMC at PV may not condition my treatment on whether I sign this authorization form unless specified above under Purposes of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize Hackensack UMC at PV to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

Verified by: _____

DO NOT WRITE IN THIS AREA

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