HUDSON
REGIONAL HOSPITAL

55 Meadowlands Parkway
Secaucus, NJ 07094
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201-392-3527
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Authorization to Release Health Information

Patient Name: ___________________________Date of Birth: ____/____/____ SS#:______________

Address: ____

____Phone#: ________________________________

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The type and amount of information to be used/disclosed/reviewed as follows:
(include dates where appropriate)

- ☐ Inpatient from (date) ______________ to (date) _______________
- ☐ Outpatient from (date) ______________ to (date) _______________
- ☐ Emergency Room from (date) ______________ to (date) _______________
- ☐ Laboratory Specimen Slides from (date) ______________ to (date) _______________
- ☐ Laboratory results from (date) ______________ to (date) _______________
- ☐ X-ray imaging reports from (date) ______________ to (date) _______________
- ☐ Entire record from (date) ______________ to (date) _______________
- ☐ Other ____

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4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to/used by/reviewed by the following individual or organization:

Name: ____

Address: ____

___________________________________ Phone#: __________________________________

6. Purpose: (Please check one):
Continuing medical care ___ Insurance application/claim ___ Attorney/legal issue___ Other ___

7. I understand that the information to be disclosed from my records is confidential and is protected by federal and state law. 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 that I may inspect of copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure to third parties, who may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

8. I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the Privacy Officer at Hudson Regional Hospital. My revocation will be effective immediately upon Hudson Regional Hospital's receipt of my written notice; however, I understand that the revocation will not apply to information that has already been released in response to this authorization prior to receiving the revocation notice. I understand that the revocation will also 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 six months.

9. I understand that Hudson Regional Hospital will notify me of its decision to approve or deny my request to access or obtain a copy of my requested health information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at Hudson Regional Hospital or within sixty (60) days if the requested information is not maintained or accessible on-site at Hudson Regional Hospital. If Hudson Regional Hospital is unable to comply with my approved request for my health information maintained or accessible within thirty (30) days, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing.

10. I understand that Hudson Regional Hospital may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law; I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Hudson Regional Hospital who did not participate in the Hudson Regional Hospital decision to deny my request. These and other actions are included in Hudson Regional Hospital's Notice of Privacy Practices.

11. I understand that any information provided pursuant to this request will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law.

12. I have read and understand the terms of this Request and I have had the opportunity to ask questions about my rights to access my health information and any Protected Health Information (PHI) that Hudson Regional Hospital uses to make medical decisions about me. I also understand that if I have further questions or concerns regarding my PHI, I may contact Hospital Regional Hospital's Privacy Officer at: Hudson Regional Hospital Privacy Officer, 55 Meadowlands Parkway, Secaucus, NJ 07094; or by telephone at 201-392-3224. Please note that a fee may be applied for certain labor, supplies, and postage associated with producing your request.

I hereby authorize Hudson Regional Hospital to release/disclose the health information listed above for the purposes described in this authorization. I certify I am the individual authorized to sign this form and understand that the knowing or willful request for or acquisition of a record (or material's with patient's identification) pertaining to an individual under false pretenses is a criminal offense under the Privacy Act subject to a $5,000 fine.

____ ________________________

Signature of Patient or Legal Representative Date

____ ________________________

If signed by Legal Representative, Relationship to Patient Signature of Witness