



228 Lafayette Street, Newark, NJ 07105  
 69 Pulaski Street, Newark, NJ 07105  
 332 South 8<sup>th</sup> Street, Newark, NJ 07103  
 491 Clinton Avenue, Newark, NJ 07108  
 Telephone (973) 789-8111

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Patient Name (Last, First): \_\_\_\_\_ DOB (MM/DD/YYYY): \_\_\_\_\_  
 Account #: \_\_\_\_\_ MRN #: \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home/Cell Telephone #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Email Address (Please Print):** \_\_\_\_\_

**RECIPIENT:** Name of Organization/Individual to whom the Hospital/Medical Facility may disclose my health information including recipient's address, telephone, and/or fax #, as applicable. *(Note: for pick-up by another individual (ID will need to be presented by the individual for verification.)*

**Recipient Name:** \_\_\_\_\_

**Recipient Address:** \_\_\_\_\_

**Recipient Fax #:** \_\_\_\_\_ **Recipient Telephone #:** \_\_\_\_\_

**Date(s) of Treatment to be disclosed:** \_\_\_\_\_

**Type of information to be disclosed:** (Check the appropriate boxes and include other information where indicated)

<input type="checkbox"/> Demographics <input type="checkbox"/> Consultations <input type="checkbox"/> Medical Abstract <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Pathology Report <input type="checkbox"/> If applicable: pictures, images, videos. Must specify procedure date: _____	<input type="checkbox"/> History & Physical <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Lab Report(s) <input type="checkbox"/> Complete Record <input type="checkbox"/> Radiology Report <input type="checkbox"/> Other: _____
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**Purpose of Disclosure:**

<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> Personal	<input type="checkbox"/> Legal Matters <input type="checkbox"/> Disability <input type="checkbox"/> Other: _____
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**Delivery Options:**

Paper ( ) For Pick-up ( ) US Mail to above address  
 Electronic (format to be mutually agreed upon): \_\_\_\_\_

I understand that the information to be disclosed includes my identity, diagnosis and treatment including **ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS, and HIC, SEXUALLY TRANSMITTED, TUBERCULOSIS,** and other **INFECTIOUS DISEASE** information, as applicable.

This authorization will automatically expire in 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: \_\_\_\_\_

**Patient/Legal Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_