HACKENSACK PEDIATRICS

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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

Patient Name	Date of Birth	Social Security Number

Address (Street, City, State, Zip Code)	Telephone Number

The following individual or organization is authorized to make the disclosure:

☐ Hackensack Pediatrics

☐ Other (please specify name & address) _____

_____

This information may be disclosed to and used by the following individual or organization:

☐ Hackensack Pediatrics, 177 Summit Avenue, Hackensack, NJ 07601

☐ Other (please specify name & address) _____

_____

Treatment dates:	Purpose of Request:

The following information is to be disclosed: (please check)

Yes	No	
☐	☐	**.....Immunization Records**
☐	☐	**.....Summary of problem list and medications**
☐	☐	**.....Initial History and Physical Exam**
☐	☐	**.....Last annual check-up**
☐	☐	**.....Growth Chart**
☐	☐	**.....Laboratory Reports (including drug screens)**
☐	☐	**.....Radiology or Imaging Reports**
☐	☐	**.....Specialist Reports**
☐	☐	**.....Developmental evaluation including social history and psychiatric diagnoses**
☐	☐	**.....Complete Record**
☐	☐	**.....Other _____**

Processing Charges: As per N.J. State Law, we reserve the right to charge up to $1.00 per page with a minimum of $10.00 and a maximum of $100.00 for the entire record, per patient.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I do not specify an expiration date, event or condition, this authorization will expire in six months. ----------

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

If I have any questions about disclosure of my health information, I can contact the Office Manager at 201-487-8222.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient