□ WCRH · Inpatient	□ MDC · Pennsauken	□ Outpatient · Marlton
	□ MDC · Vineland	□ Outpatient · Northfield
		□ Outpatient · Washington Twp.

Authorization for Disclosure of Health Information

I hereby authorize ____ ______________________________________ to release medical information of:
Patient Name: ____ **D.O.B.**__________________
Covering the period(s) of care (list applicable dates of treatment):______________________________
Information to be disclosed (check all applicable items to be released):

- □ Discharge Summary
- □ PT/OT/ST Notes
- □ Progress Notes
- □ Medication Records
- □ History & Physical
- □ Consultations
- □ Teaching/Education Forms
- □ Initial Evaluation
- □ Other :___________ ____

I hereby authorize the above noted facility to disclose the health information as described above. I understand that such disclosure may include information of a more sensitive nature, such as records related to: mental or behavioral health, substance use disorder (drug or alcohol abuse), genetic diseases or testing, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS). I specifically authorize the disclosure of such sensitive health information to the person or institution noted below.

I understand that this authorization shall operate as a complete release of liability to the facility location(s) specified above, and its trustees, officers, employees, and agents, for the disclosure of the health information as described above.

I understand that the health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and/or state law.

This information is to be disclosed to:
Name of Person or Institution:______________ ____
Address:____
City/State/Zip Code:____ Phone: _______________________
For the purpose of (required): □ Patient personal use □ Other (please describe):_________________
Delivery Options:
□ Release as printed paper copy & mail □ Release to encrypted USB □ Fax
□ Encrypted Email or Third Party Portal: (Print Address Clearly) _____________________________

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated to expire on ___________(Date not to exceed 6 months). In accordance with Federal and NJ state law, I understand that the facility noted above may charge a fee for obtaining copies of records, except for copies mailed directly to a healthcare facility or physician for continuing care purposes, and I agree to pay such charges.

_______________________________________ ________________ ________________
(Signature of Patient or Authorized Representative) (relationship to patient) (Date)

Note to Recipient of Information (as applicable): This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65

INSTRUCTIONS FOR COMPLETING THE
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM

1. Please complete the Authorization for Disclosure of Health Information Form in its entirety. Incomplete forms will be returned to the sender for completion.
2. Please return the form to:

   Fax: (856) 810-3747
   Email: HIMROI@WEISMANCHILDRENS.COM
   US Mail: Weisman Children's Rehabilitation Hospital
   Health Information Management Department
   Business Office, Suite 302
   92 Brick Road
   Marlton, New Jersey 08053
3. Records for all purposes except continuing care are subject to copying charges in accordance with Federal and NJ State Law. An invoice will be delivered to you and payment will be expected prior to the records being delivered.

Page(s)	Fee
1 – 100	$1.00 per page
101 – or greater	$0.25 per page

Please contact the Health Information Management Department (Medical Records) at the contact information provided below if you have additional questions or need further assistance.

Phone: (856) 489-4520 x204
Fax: (856) 856-810-3747