St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center
St. Joseph's Healthcare and Rehab Center

703 Main Street, Paterson, NJ 07503
Phone: (973) 754-2603 Fax: (973) 754-4053

224 Hamburg Tpke, Wayne, NJ 07470
Phone: (973) 956-3715 Fax: (973) 956-3731

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Street Address: _____

City, State, ZIP: _____ Telephone: _____

Email Address: _____

I hereby authorize and request St. Joseph's Health to release information related to treatment at:

☐ SJH - Paterson ☐ SJH - Wayne ☐ SJH Physician Practice ☐ SJH Outpatient Clinic/Center ☐ SJH Urgent Care

INFORMATION TO BE RELEASED TO (RECEIVER): ☐ Check if same as patient

Facility or Person: _____ Attention to: _____

Street Address: _____

City, State, ZIP: _____ Telephone: _____

Email Address: _____ Fax: _____

INFORMATION TO BE RELEASED/OBTAINED:

☐ INPATIENT ABSTRACT (includes discharge summary, history and physical, consults, operative reports, clinical information as appropriate) FOR DATE(S): _____

☐ INPATIENT COMPLETE RECORD FOR DATE(S): _____

☐ OUTPATIENT RECORD FOR DATE(S): _____

Please specify which outpatient department(s):

☐ Emergency Dept. ☐ Same-Day Surgery ☐ Lab ☐ Imaging/Radiology
☐ Cardiology ☐ Physical Therapy ☐ Other: _____

SENSITIVE INFORMATION:

I specifically authorize the use and/or disclosure of the following highly confidential information as indicated by my initials:

Please initial if requested:

_____ HIV/AIDS _____ Behavioral Health _____ Tuberculosis _____ Reproductive Health
_____ Genetic Information _____ Alcohol/drug use _____ Sexually Transmitted Infections

FORMAT OF INFORMATION:

☐ Paper ☐ CD delivered to above address ☐ CD pickup ☐ Email (secure)

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expired on _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

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 in order to receive treatment, payment, enrollment or eligibility for benefits. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

X _____ _____
Signature of Patient or Legal Representative Date / Time

X _____
If signed by Legal Representative, Relationship to Patient

NOTICE TO RECIPIENT OF INFORMATION

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (41 CRF Part 2) prohibits you from making further disclosure is expressly permitted by the written consent of the person to whom it pertains, 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Upon receipt of proper request in writing, all requests will be processed in accordance with N.J.A.C. 8:43G-15.3

FEE SCHEDULE FOR OTHER REQUESTS:

- Photocopies of the record will be provided at a one-time fee of $0.12 per page
- Electronic copies will be provided for a flat fee of $6.50
- Hybrid (part electronic/part paper) will be provided at flat fee of $6.50 plus applicable $0.07 per page
- $30.00 per CD for Radiology Requests, plus $10.00 processing and labor fee; no fee for initial request

FEE SCHEDULE ABOVE IS NOT APPLICABLE FOR THE FOLLOWING:

1. **Records mailed directly to a Physician/Health Care Facility**
   The facility will mail copies of request records directly to a Physician/Health Care Facility at no charge to the patient.

2. **Medical Emergency Case (records needed for medical care within 48 hours or less)**
   Written consent by Patient/patient Representative is required.
   Arrangement will be made for a scheduled pickup or records may be faxed per direct request from treating physician.
   The physician's name, address, phone number, fax number (if applicable), and appointment time is mandatory for above transaction.

3. **Attorney, Insurance Companies, Workers Compensation and other agencies**
   Regulatory statutes for search fees and per page fees will apply, including a maximum per admission/encounter fee of $50

FOR DEPARTMENT USE ONLY

If the patient is a minor, a parent, next of kin or legal guardian must sign the authorization with the following exceptions and as prohibited by law:

☐ The minor is pregnant ☐ The minor is married ☐ The minor is emancipated (court determined)

☐ The treatment is a stated funded mental health service ☐ The treatment if for Drug and/or Alcohol Abuse

☐ The treatment is for Sexually Transmitted Disease ☐ The treatment is for AIDS or HIV

IDENTIFICATION VERIFIED VIA:

☐ Driver's License ☐ Other: _____

IF COPIES ARE HANDED, OBTAIN SIGNATURE BELOW:

Signature: _____ Date/Time: _____