Atlantic City
MEDICAL CENTER

INFORMED AUTHORIZATION / CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE THE ATLANTIC CITY MEDICAL CENTER TO: ( ) RELEASE ( ) OBTAIN
THE MEDICAL RECORDS OF: ______________________________
WHOSE DATE OF BIRTH IS: ______________________________
AND DATE OF TREATMENT WAS: ______________________________
( ) TO RELEASE TO: ( ) TO OBTAIN FROM: ______________________________
____
____
FOR THE PURPOSE OF: ______________________________
____
PLEASE CHECK THE PROPER CATEGORY/TYPE OF PATIENT VISIT:
( ) OUTPATIENT ( ) EMERGENCY ROOM ( ) CLINIC ( ) INPATIENT
PLEASE CHECK WHAT IS SPECIFICALLY TO BE RELEASED:
( ) DISCHARGE SUMMARY ( ) REPORT OF OPERATION ( ) PATHOLOGY
( ) LABORATORY TESTS ( ) RADIOLOGY ( ) E.K.G.
OTHER: ______________________________

I UNDERSTAND THAT THESE MEDICAL RECORDS MAY OR MAY NOT CONTAIN INFORMATION PERTAINING TO PSYCHIATRIC COUNSELING OR TESTING; ALCOHOL OR DRUG ABUSE COUNSELING OR TESTING; AND/OR H.I.V. / A.R.C. TESTING. I DO EXPRESSLY AND VOLUNTARILY AUTHORIZE THE DISCLOSURE OF THE SAID MEDICAL RECORDS TO THE PERSON(S) AND/OR ENTITY(IES) AS STATED ABOVE. I ALSO UNDERSTAND THAT THESE RECORDS MAY BE RELEASED VIA THE U.S. POSTAL SERVICE, AN OVERNIGHT DELIVERY SERVICE OR BY WAY OF TELEFAX. THIS AUTHORIZATION / CONSENT WILL REMAIN IN EFFECT FOR A PERIOD OF ONE YEAR FROM THE DATE STATED BELOW, UNLESS REVOKED IN WRITING BY THE PERSON TO WHICH IT PERTAINS (OR HIS OR HER PARENT, LEGAL GUARDIAN OR LEGALLY AUTHORIZED AGENT), TO THE MEDICAL RECORDS DEPARTMENT. THESE MEDICAL RECORDS ARE BEING DISCLOSED UNDER THE PROVISIONS OF APPLICABLE NEW JERSEY STATE AND FEDERAL LAW.

NOTICE TO THE RECIPIENT OF RECORD:

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL LAWS OF CONFIDENTIALITY (42 C.F.R. PART 2). THESE LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THESE RECORDS, UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION BY THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 C.F.R. PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF THESE MEDICAL RECORDS IS NOT SUFFICIENT FOR THIS PURPOSE. YOU MAY ONLY USE THESE MEDICAL RECORDS FOR THE PURPOSE(S) AS STATED ABOVE.

DATED THIS ________ DAY OF ____________, 20____.

______________________________ ______________________________
(WITNESS) PATIENT SIGNATURE, PARENT, LEGAL GUARDIAN, OR LEGALLY AUTHORIZED AGENT)

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