

RELEASE TO: Person/s Name _____
Organization _____
Street Address _____
City/State/Zip _____

COMMENTS: None

I do hereby consent to and authorize the Virtua West Jersey Hospital specified above to disclose to the person/organization named above information from my medical records relating to my identity, diagnosis, prognosis, treatment and condition, including: psychological or psychiatric impairment; drug abuse and/or alcoholism; sickle cell anemia; and acquired immunodeficiency syndrome (AIDS) and/or tests for infection with human immunodeficiency virus (HIV).

Release is to be limited to the specified report(s) within the specified date(s) of treatment detailed above. I understand that this consent shall operate as a complete release of liability to the Virtua West Jersey Hospital specified above, its trustees, officers, agents and employees for the release of information as specified above.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient noted above and in that case, will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that HIPAA, and its implementing regulations ("HIPAA") govern the terms of this authorization. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not revoke this consent, it will terminate six (6) months from the date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

PATIENT or PATIENT REPRESENTATIVE SIGNATURE DATE SIGNED

If Patient Representative, give relationship to Patient