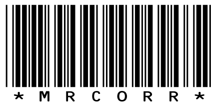

THE VALLEY HOSPITAL
223 N. Van Dien Avenue
Ridgewood, New Jersey 07450
201-447-8111
201-447-8648 Fax

Authorization for Release of Medical Records

Doctor's Appt Date/Time:

Section A: This must be completed for all Authorizations

Patient Name:	Date of Birth:	Patient's Phone:

Recipient's Name:

Recipient's Address:	Recipient's Phone:

City:	State:	Zip:

Request Delivery method (if left blank, a paper copy will be provided): ☐ **Encrypted Email** ☐ **Unencrypted Email** ☐ **Encrypted CD**
☐ **Unencrypted CD** ☐ **Paper Copy** ☐ **Pick Up** ☐ **Electronic Image Sharing** (see page two for image types)
☐ **Send to Patient Portal (Separate from Portal Sign-up)**
☐ **Fax Number** ______________________________

NOTE: If the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). We are not responsible for unauthorized access to the Protected Health Information (PHI) contained in this format or any risks (e.g., virus) potentially introduced to your or a third party's computer/device if you request that PHI be sent in electronic format or email.

Email Address (if email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both. If Date or Event not filled out, authorization will expire 1 year after date of signing): **Date**: ____________________ **Event**: ______________________________

Purpose of release: ☐ **Physician** ☐ **Facility** ☐ **Second Opinion (Treatment)**
☐ **Personal Use** ☐ **Legal** ☐ **Other:** ______________________________

Description of information to be used or disclosed

I acknowledge that if my health information contains alcohol/drug abuse/use and related treatment, genetic information, mental/behavioral health, tuberculosis, sexually transmitted disease, HIV testing, HIV results or AIDS information, such information will be disclosed to the recipient identified above, and I hereby consent to disclosure of such information.

Type of Information:	*Date(s) of Visit:*	*Type of Information:*	*Date(s) of Visit:*
☐ Abstract (pertinent documents for doctor appointments		☐ Images	
☐ Test Results (Lab, EKG, X-rays, Pathology). Please Specify:		☐ Entire Chart (Legal purposes)	
☐ Emergency Room Visit/test(s)		☐ Other:	

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits shall not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Details on how to revoke this authorization are found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations and may be re-disclosed by the recipient. State law limiting re-disclosure of HIV/AIDs information, generic information and other specifically protected categories shall continue to apply to any recipient of such information.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I understand the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as may be amended from time to time.
7. I can get a copy of this form after I sign it.

Section B: Signatures - Please sign below.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative: (Ex: POA, Executor, Legal Guardian)	**Representative Authority:**
Name of Person Other than Patient Picking up Records:	**Relationship to Patient:**

Directions for Completing the Authorization to Release Information
***Note: Release of information will occur after hospital discharge

Section A:

- Provide the patient's name, date of birth, and phone number.
- Provide the name of the recipient (receiver) of the information. The recipient is whoever is going to receive the records. The recipient of the information may be someone other than the patient. It may be the patient's spouse, parent, power of attorney, another healthcare provider, etc. If the recipient's name is the same as the patient, just write "SELF."
- If the recipient is the patient, provide the address of the patient. If the recipient is different than the patient, provide the address and phone number of the recipient.
- Next check the method of delivery: paper copy, electronic copy (CD) or electronic image sharing, (vascular lab, CT, mamo, MRI/MRA, x-ray, bone density, PET, ultrasound), email or pick up. If you want the information faxed, indicate the fax number. If you choose the option to send to the patient portal, please sign up for the portal separately if you do not already have access (images cannot be sent to the portal). If by email, provide the email address. **Please note: Any information not picked up within 5 business days once completed, will be mailed to address provided.** When requesting medical records to be sent unencrypted via email or CD, your health information is not protected from unauthorized access. **NOTE**: If the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). We are not responsible for unauthorized access to the Protected Health Information (PHI) contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.
- Indicate when this form expires. Put a date or an event (event example: the end of my outpatient therapy), but not both. If no date or event is listed, the authorization will expire 1 year after date of signature.
- Provide the reason for disclosure, examples are: further treatment, insurance purposes, for attorney, personal use, etc.
- At **DESCRIPTION** indicate what information you are requesting. Most common is the abstract, which contains the discharge summary, history and physical, ER report, consults and operative reports from the physicians, along with test results such as labs, radiology, and pathology. Otherwise, indicate the specific information you need. Please indicate the dates of service.
- Initial that you acknowledge and consent that the information requested may contain the special types of information listed.
- There may be a copy fee for the information you requested. Most requests will be sent to our copy service called MRO Disclosure Management Solutions. Their contact information to ask questions, check status, or make a payment is 888-252-4146, Option 1, Fax: 610-962-8421, or Email: requestinformation@mrocorp.com.
- This authorization shall not be used to disclose protected health information for marketing purposes and/or the sale of protected health information.

Section B:

- The patient must sign and date the form. OR,
- The patient's LEGAL representative must sign and date the form. **Examples of appropriate "Representative Authority" include but are not limited to: power of attorney, legal guardian, or healthcare surrogate. (A spouse is not a LEGAL representative unless they have LEGAL power of attorney or healthcare surrogacy paperwork.) A copy of the LEGAL paperwork must be submitted with this request**.
- Patients over 18 years of age must request their own records, unless otherwise legally unable to sign this authorization.
- Please send a copy of the patient's ID or the legal paperwork mentioned above, along with this request, to The Valley Hospital, HIM Department, 223 N. Van Dien Ave, Ridgewood, NJ 07450.