* M R C O R R *

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

Upcoming 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): ☐ Paper Copy ☐ Pick Up ☐ Electronic Image Sharing (see page 2)

Email: ☐ Encrypted ☐ Unencrypted **CD:** ☐ Encrypted ☐ Unencrypted ☐ Fax # _____

***Medical records prior to 2015 will be sent to the patient portal.**

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: ☐ **Facility/Physician Disclosure** **Physician Name:** _____
☐ **Treatment** ☐ **Personal Use** ☐ **Legal** ☐ **Other:** _____

Description of information to be used or disclosed ***(please check all that apply and include date(s) as applicable)***

Type of Information:	***Date(s) of Visit:***	***Type of Information:***		***Date(s) of Visit:***
☐ Abstract		☐ Recovery & Wellness Unit		
☐ Emergency Room Visit/test(s)		☐ Lab Results	*(please specify)*	
☐ Entire Chart * **See instructions**				
☐ Bone Density				
☐ CT		☐ Images	*(please specify)*	
☐ MRI/MRA				
☐ PET				
☐ Ultrasound		☐ Other:	*(please specify)*	
☐ X-Ray				
☐ Echo				

I acknowledge that if any of the above checked health information contains alcohol/drug abuse/use and related treatment, genetic information, mental/behavioral health, tuberculosis, sexually transmitted disease, HIV testing, HIV/AIDS results and related information, and/or any communication or information regarding reproductive health services information, ("Sensitive Information"), such Sensitive Information will be disclosed to the above recipient. subject to the requirements in A.10 of the Instructions, and I hereby consent to disclosure of such information.

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, by sending my written revocation to The Valley Hospital, Inc. 223 N. Van. Dien Ave., Ridgewood, NJ 07450, Attn: Compliance Officer. I further understand that my revocation of this Authorization will not have any effect on any actions taken prior to receiving the revocation.
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 specifically protected categories may 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, and other state and federal laws, as may be amended from time to time.
7. I can get a copy of this Authorization after I sign it.

Section B: Signatures - Please sign below.

I have read the above and authorize the disclosure of my Medical Record as described in this Authorization.

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:

1. Provide the patient's name, date of birth, and phone number.
2. 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."
3. 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.
4. 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, nuclear medicine), 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. When requesting medical records to be sent unencrypted via email or CD, your health information is not protected from unauthorized access. If you choose to receive emails in an unencrypted manner, there is an increased chance and you accept the risk that your health information could be compromised if emails are lost in transmission, hacked by a third party or accessed by the wrong recipient.
5. **NOTE**: If the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).
6. **Any information not picked up within 5 business days once completed will be mailed to address provided.**
7. 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.
8. Provide the reason for disclosure, examples are: further treatment, insurance purposes, for attorney, personal use, etc.
9. 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. Please indicate the dates of service.
10. **SENSITIVE INFORMATION REQUIREMENTS**: Sensitive Information that may be in your record will generally be released along with any record request made pursuant to this Authorization. For example, an HIV positive test result would be released if the Lab Results box was checked. However, Recovery & Wellness Unit (inpatient substance use treatment unit) records will not be included in any request unless the "Recovery & Wellness Unit" box is selected. If requesting the "Entire Chart" and you wish to also include Recovery & Wellness Unit records related to inpatient substance use treatment, both the "Recovery & Wellness Unit" box and the "Entire Chart" box must be checked off.
11. **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.**
12. This authorization shall not be used to disclose protected health information for marketing purposes and/or the sale of protected health information.

Section B:

1. The patient must sign and date the form. OR,
2. 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**.
3. Patients over 18 years of age must request their own records, unless otherwise legally unable to sign this authorization.
4. 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.