The Valley Hospital
Ridgewood, New Jersey

Doctor's Appt date:____________________
Time: __________________ (when applicable)

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS & INFORMATION

I, ____, born on ______________________________
(Name of Patient) **(Date of Birth)**

do hereby consent and authorize The Valley Hospital to disclose to:

____ located at ________________________________
(Name of person*, Physician, or other Hospital/Rehab Facility) **(Address and Phone Number)**

____

the following type of information from the hospital records:
____

and the purpose or need for this disclosure is ____
(Doctor's appointment, personal use, etc.)

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization , I must do so in writing and present my written revocation to the Privacy Officer at The Valley Hospital, 223 North Van Dien Avenue, Ridgewood, N.J. 07450. 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.

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition or in one year:__________

***Please note, all copies for patient records for personal use carry a $1 per page fee. The State of New Jersey allows 30 days to comply with a record request and walk-ins will be handled accordingly unless there is an emergency.** If you are picking up the records personally, you will be required to show a legal form of identification.

Please indicate type of record(s) requested and approximate date(s) of service (please check box(s) below):

☐ Inpatient	Date(s) in hospital from – to:	☐ Outpatient	Date(s) in hospital from – to:
☐ Emergency Room	Date(s) in ER:	☐ Clinic	Date(s) in Clinic from – to:
☐ Test results only	Date(s) of Test:	Type of Test(s): ☐ X-ray ☐ Labs ☐ Pathology ☐ Vascular ☐ EKG ☐ Echocardiogram ☐ Other: __________	

Today's Date: ______________ **Patient's Signature:** ______________________________

Parent/Legal Guardian or Authorized Representative: ______________________________

Witness to Signature(s): ______________________________

*** Name of person, other than requestor, picking up copy of medical record:** ____________________
***Children over 18 years of age must request their own records.**

If it is determined by the hospital that your records are protected by Federal or State law and regulations concerning confidentiality of alcohol and drug abuse patient records, the diagnosis and treatment of AIDS, HIV infection or HIV related illness; the following note will be attached to the information sent to the recipient. **If you fail to specify an expiration date, event or condition, this authorization will expire in 1 year.**

NOTE to Recipient of Information: This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CFR § 2.1 et seq; N.J.S.A. 26:5c-1 et. Seq.) Federal or State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR § 2.1 et seq. or N.J.S.A. 25:5c-1, et seq. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal or State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.