Short Hills Surgery Center

Authorization for Release of Information

I do hereby consent to and authorize Short Hills Surgery Center to disclose to the person(s) named, information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to the Center and to its employees for the release of information as specified below.

PURPOSE* Date

**For continuing care purposes we send directly to the physician/facility at no charge. All other requests will be subject to a fee of $1.00 per page. If needed for an upcoming appointment, please indicate the date of the appointment so that we may properly prioritize the request.*

PATIENT NAME PHONE DOB

TREATMENT DATES NEEDED

SPECIFIED REPORTS: (Check appropriate box)

☐ Abstract: face sheet, history & physical, discharge summary, all medical tests, operative section
☐ All Medical Tests: labs, EKG, x-ray, operative section
☐ Entire Record
☐ OTHER_____

RELEASED TO:
Name Phone
Complete Address
Special Instructions_____ To be: ☐ Picked up ☐ Mailed

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunideficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Unless otherwise revoked by me, this authorization is valid for 6 months from the date above. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this authorization.

I understand that once the Center discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, the Center cannot guarantee that the Recipient will not disclose the information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

I understand that my medical record related to the above treatment date is an incomplete record. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Center to use or disclose my health information in the manner described above.

_____ _____ _____
Patient Signature Date Witness Signature

If the individual is a minor or otherwise unable to sign this Authorization, please complete the information below

_____ _____ _____ _____
Signature of Authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative | Relationship | Date | Witness Signature

NOTICE OF RECIPIENT OF INFORMATION

Each Disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules 45 C.F.R. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.