Authorization for Release of Health Information

Instructions: Sections 1-7 must be completed for all requests and signatures. Please print legibly in black ink only. Patient label is acceptable. Place label over Name, Home Address and Date of Birth and on white and yellow copies. (There is no cost for medical record copies requested for patient care. There is a charge for producing medical record copies for other than patient care per NJ State law.)

Patient Name: _____ Phone: _____
Home Address: _____
Date of Birth: _____ Social Security (last 4 digits only): _____
Email: _____

1. DATES OF SERVICE Requested: _____

2. DESCRIPTION OF INFORMATION TO BE RELEASED: *(check ALL that apply)*

☒ History and Physical	☒ Pathology report	☒ EKG or EEG	☒ Other (Specify): _____
☐ Consultation reports	☐ Discharge Summary	☐ Outpatient treatment	_____
☒ Operative report	☒ Lab results	☐ Inpatient treatment	_____
☒ Anesthesia record	☒ Imaging (report or study)		

3. SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE: I understand my records may contain any of the following if applicable: HIV/AIDS, Sexually Transmitted Disease, Mental Health and/or Psychiatric information, Drug and Alcohol usage and treatment and/or Genetic Information:
Please indicate if you do not want any of this information released and specify: _____

4. PURPOSE OF RELEASE: I authorize **PRINCETON HEALTHCARE SYSTEM** to release my health information for the following specific purpose: ☐ Continuing Care ☐ Self ☒ Insurance ☐ Verbal Release
☐ Other (please explain): _____

5. RELEASE INFORMATION TO:
Individual/Contact: _____ Organization: Hoosier Services Inc.
Street Address: 18032 Lemon Dr.#C-618 City: Yorba Linda St: CA Zip: 92886
Phone: 800-882-4156
☐ FAX (can fax only to other health care providers); Health care provider fax #: 800.882.4957
☐ E-MAIL address: _____ (For patients only. You will receive e-mail instructions from us where you will be directed to a secure site to retrieve your records.)
☐ Princeton Health*Connect* Patient Portal)For patients only, further instructions will be provided. Note: this option excludes Princeton House Outpatient Behavioral Health.)
☐ MAIL ☐ PICK-UP ☒ Other (Specify): service@hoosierservicesinc.com

6. TERM/EXPIRATION: This signed Authorization **will expire in 60 days** unless you indicate otherwise below. This Authorization will no longer be valid after: _____ (Specify date or revised authorization days)

7. SIGNATURE OF AUTHORIZATION
I hereby authorize ***PRINCETON HEALTHCARE SYSTEM*** to release/disclose the health information listed above for the purposes described in the Authorization and have reviewed the Important Information on the back of this form.
Patient Signature: X _____ Date: _____ Time: _____
If minor or unable to sign, signature required of the authorized individual.

Name of Authority, if applicable (print): _____

Relationship of Authority: ☐ Next of Kin ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Signature of Authority: _____ Date: _____ Time: _____

For Internal Use Only:
Witness Name (print): _____
Witness Signature: _____ **Date/Time:** _____
Date of Receipt: _____ **Med Rec No:** _____ **Notes:** _____