RIVERFIELD
FAMILY HEALTH
CENTER

1738 ROUTE 31 N SUITE 203
Clinton, NJ 08809
PHONE (908) 735-4645
FAX (908) 735-7361

www.hunterdonhealthcare.org

Authorization for Disclosure of Protected Health Information

I, _____ hereby authorize _____

to disclose information from the record of: _____ _____
Patient's Name Date of Birth

The Information is to be:

Released from: Riverfield Family Health Center

To: Hoosier Services Inc
18032 Lemon Dr.,#C-618
Yorba Linda, CA 92886
Fax:800-882-4957
Phone:800-882-4156
Please FAX med records to us

OR

Release to:
Riverfield Family Health Center
1738 Route 31 North, Suite 203
Clinton, NJ 08809
Tel: (908)-735-4645 Fax: 908-735-7361
From: _____

Purpose for request:

_____ **For personal use only** (not transferring from practice

_____ **Relocation out of area**

_____ **Insurance change related** (please indicate carrier _____)

_____ **Transferring care to another local Practice due to:** _____

X **Other:** insurance-Banner

The Following information is to be released: (please check one)

_____ **Entire Medical Record**. Records specifically protected under State and Federal Confidentiality Statues. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and Federal Law and prohibits any further disclosure without written consent of the persons to whom it pertains or otherwise provided by law.

X **Only Specific portions of the medical record.** Itemize portions of record and time period of records to be released and indicate specific records that may not be released. _____

Having read the above information, I release Hunterdon Healthcare Systems, its employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of information set forth above relating to my protected Health Information.

I understand that this authorization will remain in effect for 180 days or until I provide a written notice of revocation to Hunterdon Healthcare System's Privacy Officer at the address listed below. The revocation will be effective immediately upon Hunterdon Healthcare System's receipt of the written notice. I understand that revocation may not be made if the action has already been acted upon based on prior authorization.

_____ _____
Date of signature: Patients Signature

_____ _____
Witness Signature of Responsible Party

If patient is unable to sign, complete the following:

_____ Patient is a Minor _____ years of age

_____ Patient is Unable to sign because _____

Privacy Office Health Information Management Services, 2100 Wescott Drive, Flemington, NJ 08822 Phone: 908-237-5478 email: Privacy.office@hunterdonhealthcare.org Federal and State Statues: Psychiatric Treatment (NJSA 10:37-6.79 et seq.), Drug, Alcohol (42 CFR Part 2), HIV-realted information (NJSA 26:5c to 25:5c-14) Genetic Information (NJSA 10:5-47 &48), Venereal Disease (NJSA 2o:,4-41) and tuberculosis Inforamtion (NJAC 8:57-5:14).

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