CareWell Health
MEDICAL CENTER
300 Central Avenue, East Orange, NJ 07018

APPLY PATIENT LABEL HERE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: ____
Last First Middle

Home Address: ____

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Telephone: ____________________ **Date of Birth:** ____________________

SPECIFY INFORMATION TO BE DISCLOSED: **Date of Service:** ____________________

- ❑ Complete Record
- ❑ Abstract: Facesheet, ED Record, Discharge Summary, History and Physical Report, Consultation Reports, Operative Reports, Pathology Reports, Diagnostic Tests, Rehabilitation Reports.
- ❑ Specific report and/or test result: ______________________________
- ❑ Do not release Psychiatric / Alcohol / Drug records.

MY HIGHLY CONFIDENTIAL INFORMATION:
By signing my name next to a category of highly confidential information listed below, I specifically authorized the use and/or disclosure of that type of information pursuant to this authorization:

- Psychotherapy notes: ____________________
- HIV/AIDS related information: ____________________
(including the fact that an HIV test was ordered, performed or reported, regardless of whether the results were positive or negative)
- Substance Abuse: ____________________
- Genetic information: ____________________
- Venereal Disease information: ____________________
- Tuberculosis information: ____________________

RECIPIENT:
Requestor: ______________________________
Address: ______________________________ Contact: ____________________
______________________________ Contact # ____________________

TERM: This authorization will remain in effect:
- ❑ From the date of this authorization until the ________ day of ____________________, 20 ______, or at the time the request is satisfied, whichever is sooner.
- ❑ Until the following event occurs: ______________________________
- ❑ Other: ______________________________

PURPOSE: I authorize CWH to use or disclose my health information, including the highly confidential information selected above during the term of this authorization for the following specific purpose:

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I understand that once CWH discloses my health information to the recipient, CWH cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable Federal and State law governing the use and disclosure of my health information.

I understand that CWH may, directly or indirectly, receive communication from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not effect the commencement, continuation or quality of any treatment at CWH, except, however, if any treatment at CWH is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case CWH may refuse to treat me if I do not sign this authorization.

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to CWH's Privacy Officer. The revocation will be effective immediately upon CWH's receipt of my written notice, except that the revocation will not have on any action taken by CWH in reliance on this authorization before it received my written notice of revocation.

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. By my signature below, I hereby, knowingly and voluntarily, authorize CWH to use or disclose my health information in the manner described above.

Signature of Patient ______________________ Date __________

If the patient is a minor or is otherwise unable to sign this authorization, obtain the following signatures:

Signature of Personal Representative ______________________ Authority ______________________ Date __________

CareWell Health Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

CareWell Health Medical Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

CareWell Health Medical Center konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.