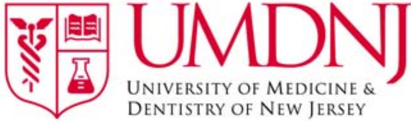

Authorization For Release of Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

1. I hereby request and authorize UMDNJ/(List Individual Unit) to release information from the health record(s) of:

______________________________	______________________________
Patient's Name	Patient's Date of Birth
Patient's Identification Number (if known)	Patient's Social Security Number

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).

2. The requested information is to be sent to (name of doctor, hospital, person or organization where records should be sent):

   Name: ______________________________

   Address: ______________________________

3. The information to be released is and the records to be sent include (please provide dates of treatment and specific records):

   ____

   ____

4. Purpose/reason for release of records (circle): Medicare Insurance Legal Matters Marketing Fundraising

   Other (explain): ______________________________

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.
6. I understand that my treatment is not conditioned on obtaining this authorization.
7. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.
8. I understand that information used or disclosed may no longer be protected by the federal privacy laws.
9. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the New Jersey Administrative Code.
10. If the requested information involves mental health information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.
11. I understand if this authorization is for marketing purposes that UMDNJ may receive direct or indirect compensation.

Printed Name of Patient: ______________________________ Date: ________________

Signature of Patient: ______________________________

Printed Name of Patient's Representative: ______________________________

Signature of Patient's Representative: ______________________________

Relationship to Patient: ______________________________