Princeton HealthCare System
MELISSA SELKE, M.D., P.C.

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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please read the information below carefully before signing this form. Print legibly in black ink only. **All fields must be completed.** Pursuant to state and federal laws, fees may apply.

Patient Name (First, Middle, Last)	Date of Birth	Phone Number
Home Address	City/State/Zip Code	

Patient label is acceptable. Place label over name, home address, and date of birth and on white and yellow copies.

I, or my authorized representative, hereby authorize **PRINCETON HEALTHCARE SYSTEM (PHCS)** to share my PHI as described below.

DATES OF SERVICE REQUESTED (list applicable dates of treatment): _____

DESCRIPTION OF INFORMATION TO BE RELEASED: (check all items to be released)

- ☐ History and Physicals
- ☐ Pathology Reports
- ☐ EKG/EEG Tests
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Lab Results
- ☐ Imaging (Report or Study)
- ☐ Treatment Plans
- ☐ Medication Records
- ☐ Physician Orders
- ☐ Other (please specify): _____

SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE: I understand that in cases where my consent is legally required, the following information will not be released unless I specifically give permission by checking the box(es) below.

- ☐ *Substance Use Treatment (Drugs/Alcohol)
- ☐ Sexual Assault
- ☐ Pregnancy
- ☐ Genetic Testing
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS (13 yrs. and older)
- ☐ Behavioral or Mental Health Treatment

* Please specify the kind and amount of information that may be disclosed. Must be limited to information necessary to carry out the purpose(s) identified below: _____

PURPOSE OF RELEASE:

- ☐ At my request
- ☐ Continuity of Care
- ☐ Other (please explain): _____

INFORMATION TO BE PROVIDED TO:

Name of Person or Institution: _____
Street Address: _____ City/State/Zip Code_____
Phone: _____ Fax (if applicable): _____

FORMAT

- ☐ Mail
- ☐ Fax (to health care providers only)
- ☐ Pick-Up
- ☐ Verbal Release
- ☐ Secure Email (patients only). Provide email address: _____
  You will receive an email from PHCS with instructions directing you to a secure site to retrieve your records.

I understand that my authorization will automatically expire **120 days** after the date of signature on this form, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: _____. I understand that I may revoke this authorization at any time by providing written notice to PHCS. The revocation will be effective except to the extent PHCS has already relied upon this authorization. Signing this authorization is voluntary. I understand that my refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing PHCS to release information as described above. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law.

Signature: _____ **Date**: _____ **Time**: _____ AM/PM
(Patient or Authorized Representative)
**If signed by anyone other than the patient, print name and relationship to patient below. Supporting documentation should be provided at the time of the request.*

Name: _____ **Relationship to Patient:** _____

NOTICE TO RECIPIENT OF INFORMATION

If the patient or their legally authorized representative authorized release of "Substance Use Treatment" information, as indicated by checking the designated boxes above on this form, the following Notice applies to the information you have received pursuant to this authorization: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

If the patient or legally authorized representative authorized release of "Behavioral or Mental Health Treatment", as indicated by checking the designated boxes above on this form, the following Notice applies to the information you have received pursuant to this authorization: This information has been disclosed to you from records protected by NJ State law. NJAC 10:37-6.79 prohibits you from making any further disclosure of these records without the authorization of the patient, or as otherwise provided by law.