REQUEST FOR MEDICAL RECORDS

Acuity Specialty Hospital of New Jersey

Third Party Request for Release of Information

I, _____ GIVE PERMISSION TO RELEASE THE PROTECTED HEALTH INFORMATION OF (PLEASE PRINT):

First Name:	MI:	Last Name:
Date of Birth:	Phone:	Last 4 digits SSN:
Address:	City:	State & Zip:

WHICH RECORDS WOULD YOU LIKE TO RECEIVE? (ENTER THE ADMISSION AND DISCHARGE DATE, THEN SELECT THE APPROPRIATE BOX(ES)):

Admission Date:		Discharge Date:	
☐ Discharge Summary	☐ Diagnostic Test Results	☐ Drug/Alcohol Records	☐ Face Sheet
☐ History & Physical	☐ Laboratory Results	☐ HIV Records	☐ Abstract
☐ Consultations	☐ X-ray/CT/MRI Reports	☐ Mental Health Records	☐ Itemized Bill
☐ Progress Notes	☐ Pathology Reports	☐ Medications	
☐ Operative Reports	☐ EKG's / ECG's	☐ Other (Please Specify): _____	

PURPOSE OF RELEASE (SELECT ONE): ☐ Request of patient/personal ☐ Medical Care ☐ Insurance ☐ Disability ☐ Worker's Compensation ☐ Legal purpose including discussions & proceedings ☐ Other: _____

HOW WOULD YOU LIKE TO RECEIVE THE REQUESTED MEDICAL RECORDS?

Select one: ☐ CD ☐ Fax ☐ E-mail ☐ Paper Copies → ☐ Mail ☐ On-site Pick Up

NOTE: E-mail and CD will be encrypted or password protected unless otherwise requested here → ☐ No encryption or password required

PLEASE INDICATE WHERE YOU WOULD LIKE THE RECORDS TO BE SENT (PLEASE COMPLETE APPLICABLE SECTION(S) BELOW):

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail:

I UNDERSTAND THAT:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.
- **THIS AUTHORIZATION WILL EXPIRE IN 6 (SIX) MONTHS OR (SPECIFY DATE OR EVENT):** _____

Relationship and authority to act*: ☐ Healthcare Agent/POA ☐ Wife ☐ Husband ☐ Guardian ☐ Next of Kin ☐ Parent ☐ Executor/Administrator/Attorney in Fact ☐ Other: _____

_____ _____ _____

Printed Name **Signature** **Date**

**** If Acuity Healthcare does not have documentation of this authority to act, you may be asked to provide copies of signed documentation of such authority.***

PLEASE RETURN COMPLETED AND SIGNED FORM TO (REQUESTS MAY BE RECEIVED VIA MAIL, FAX OR EMAIL ATTACHMENT):

Health Information Management Director - ROI Acuity Specialty Hospital of New Jersey 1925 Pacific Avenue Atlantic City, NJ08401 C/O Atlanticare Medical Center – Wellness Pavilion, 5th Floor	Fax: 609-441-8079 Phone: 609-441-8049

- There may be a fee associated with producing requested records. Please see the fee schedule for this Acuity Healthcare facility.

For Office Use Only

Date of release: _____via mail fax CD other_____ ID verified DL/Other ID_____

Employee Name & Title: _____Date: _____ Time: _____

***** ATTENTION *****

This message may contain confidential and/or privileged information. If you are not the addressee or authorized to receive this for the addressee, you must not use, copy, disclose, or take any action based on this message or any information herein. If you have received this message in error, please advise the sender by fax immediately and destroy this form. Thank you for your cooperation.