NORTHBROOK BEHAVIORAL HEALTH HOSPITAL

425 Woodbury-Turnersville Rd., Blackwood, NJ 08012-2960 **(Phone 856-374-6713 Fax 856-374-6714)**

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____ SS# _____

☐ **I authorize Northbrook Behavioral Health Hospital to release information to:**

_____ _____

Print Name/Hospital/Doctor/ Other — Phone # / Fax # (include area code)

_____ _____

Address — City, State, Zip Code

Dates of Service Requesting: _____

Information to be released:

☐ *Free Packet ☐ Complete health record(s) ☐ Discharge summary

☐ Progress notes ☐ History & Physical examination ☐ Consultation reports

☐ Laboratory tests ☐ X-ray reports ☐ Other (please specify) _____

* Free Packet includes Initial Psychiatric Assessment, Discharge Summary and History & Physical Examination

I understand that this will include information relating to (check if applicable):

☐ Behavioral Healthcare ☐ Alcohol and/or Substance Abuse ☐ HIV/AIDS ☐ Sexually Transmitted Disease

I**nformation released will be used for** ☐ Continuing care ☐ Insurance ☐ Legal ☐ Personal

☐ Other (Please Explain): _____.

- I understand that I may revoke this authorization at any time.
- I understand that the revocation will not apply to information already released in response to this authorization.
- I further authorize that a photocopy or facsimile of this authorization will be treated in the same manner as the original.
- I understand that this authorization will expire in one (1) year from the date of my signature unless otherwise specified.
- I understand that this authorization is not valid for future dates of service.
- I certify that this authorization has been made voluntarily and that the information given above is accurate to the best of my knowledge.
- I understand that this request may be entitled to a reasonable fee for the retrieval and printing/copying of records.
- If you are signing on behalf of a patient for whom you are legally responsible, you must present an appropriate certification.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any release of information carries with it the potential for unauthorized rerelease and the information may not be protected by federal confidentiality rules.

PROHIBITION OF REDISCLOSURE: Once this information has been released to you from records whose confidentiality is protected by Federal Law 42CFR Part 2 you are prohibited from making any further release of it without the specific written consent of the person to who it pertains, or as otherwise permitted by CFR42 Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signed: _____ _____

Patient — Date

_____ _____

or Legal RepresentativeRelationship to Patient — Date