ESSEX COUNTY HOSPITAL CENTER
204 GROVE AVENUE, CEDAR GROVE, NJ 07009

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

ADDRESSOGRAPH for current patient or complete below

Form # 01-01-04
Date Initiated: 1/19
Date Revised: 3/19

PATIENT NAME: ___________________________________ Date of Birth: _____________________

Address: ____ Telephone #: _____________________

____ Previous Last Name: _______________

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

☐Mental Health/Psychiatric Conditions/Diagnoses ☐Alcohol and/or Drug Abuse

☐Medical Conditions/Diagnoses ☐AIDS/HIV Infection

Information to be disclosed:

☐Initial Psychiatric Evaluation ☐Discharge Summaries

☐History & Physical Examination ☐Discharge Plans ☐Other (please specify): _________________

This information includes the following dates of treatment:

☐ Current or last inpatient hospitalization or ☐ Specify Dates: From: ___________ to: ____________

The purpose of disclosure: ☐ Mental Health/Medical Treatment ☐Other (specify):__________________

I hereby authorize ☐Clinical Staff ☐ Administrative Staff to disclose my PHI/medical records to:

Name: ____

Address: ______________________________________ City: ___________________ State: __________

Apt:___________ Zip Code:_____________ Telephone #:_____________________________

I understand this authorization may be withdrawn in writing at any time, except to the extent that action has been taken prior to receipt of my withdrawal statement. Unless otherwise withdrawn, this authorization will expire on the following date: **ONE (1) YEAR OF THE AUTHORIZATION DATE** or event, or condition:
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain a copy of the information to be disclosed, as provided in 45 CFR 164.524. Please be aware that once health information is released per your instructions the information is subject to re-disclosure. I have read and understand the nature of this release of information:

Signed: ____ ________________
Patient Signature Date

________________________ ______________________________ ________________
Legal Representative/Next of Kin Relationship to Patient Date

____ ________________
Signature of Witness Date