



Authorization to Disclose Protected Health Information

Patient's Name	Last	First	Middle
Home Address			
City		State	Zip
Home Telephone		Date of Birth	

Specify Information to be Disclosed: Entire Record

Service Date(s) or Range: _____

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Radiology Images
<input type="checkbox"/> Discharge Instructions	<input type="checkbox"/> ER Record	<input type="checkbox"/> EKG/ECG Tests	<input type="checkbox"/> Medication Records
<input type="checkbox"/> History and Physical	<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Consultations	<input type="checkbox"/> Other (please specify): _____		

Please Check All Applicable Locations:

<input type="checkbox"/> Inspira Medical Center Elmer 501 West Front Street Elmer, NJ 08318 856-363-1000	<input type="checkbox"/> Inspira Medical Center Vineland 1505 West Sherman Avenue Vineland, NJ 08360 856-641-8000	<input type="checkbox"/> Inspira Medical Center Woodbury 509 North Broad Street Woodbury, NJ 08096 856-845-0100	<input type="checkbox"/> Inspira Health Center Bridgeton 333 Irving Avenue Bridgeton, NJ 08302 856-575-4500
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My Confidential Information:

The release of my health information may include the disclosure of sensitive information including categories indicated below. Please specify any information you do not want to be released to Inspira as part of this authorization. Initial Selection

Yes	No	
		I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive
		I authorize the release of my Mental Health Information
		I authorize the release of my Drug and Alcohol Information

***This information has been disclosed to you from records whose confidentiality is protected by Federal law (42CFR Part 2) which prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulation.**

RECIPIENT (Name of person to whom Inspira Health Network may disclose my health information):

Name:	Phone#	Fax#
Address		
City	State	Zip

TERM: This Authorization will remain in effect for 180 days from the signature date unless specified below:

From the date of this Authorization until: _____

Other: _____

PURPOSE OF AUTHORIZATION:

<input type="checkbox"/> Personal Use by Patient	<input type="checkbox"/> Send to other Health Care Provider	<input type="checkbox"/> Insurance Coverage	<input type="checkbox"/> Caregiver instruction	<input type="checkbox"/> Other (please specify): _____
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AUTHORIZATION:

- I hereby authorize Inspira Health Network to disclose the health information described above.
- I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.
- I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing to: Inspira Health Network’s Privacy Office at Inspira Health Network, 2950 College Drive Suite 1E, Vineland, NJ or by email privacyoffice@ihn.org.
- I understand that any revocation will be effective immediately upon its receipt of my written notice, except that the revocation will not have any effect on any action taken by Inspira Health Network in reliance on this Authorization before it received my written notice of revocation.
- I understand that once Inspira Health Network discloses my health information to the recipient, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that I may refuse to sign (at any time) this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Inspira Health Network; except, however, if my treatment at Inspira Health Network is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Inspira Health Network may refuse to treat me if I do not sign this Authorization.

I have read and understand the terms of this Authorization. By my signature below, I hereby, knowingly and voluntarily, authorize Inspira Health Network to use or disclose my health information in the manner described above:

Signature of Patient: _____ **Date:** _____ **Time** _____

If the patient is a minor or is otherwise unable to sign this authorization, obtain the following signatures:

Signature of Personal Representative: _____

Description of Authority: _____ **Date:** _____ **Time** _____

For Hospital Use Only: A copy of this Authorization shall be placed in the patient’s medical record. Inspira Health Network must provide a copy of the signed Authorization form to the patient or representative.

Hospital Representative: _____ **Date:** _____ **Time** _____