inspira HEALTH

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:_____

☐ Discharge Summary	☐ Operative Report	☐ Lab Reports	☐ Radiology Images
☐ Discharge Instructions	☐ ER Record	☐ EKG/ECG Tests	☐ Medication Records
☐ History and Physical	☐ X-Ray Reports	☐ Progress Notes	☐ Physician Orders
☐ Consultations	☐ Other (please specify):		

Please Check All Applicable Locations:

☐ Inspira Medical Center Elmer 501 West Front St. Elmer, NJ 08318 856-363-1000	☐ Inspira Medical Center Vineland 1505 West Sherman Ave. Vineland, NJ 08360 856-641-8000	☐ Inspira Health Center Woodbury 509 North Broad St. Woodbury, NJ 08096 856-845-0100	☐ Inspira Health Center Bridgeton 333 Irving Ave/ Bridgeton, NJ 08302 856-575-4500	☐ Inspira Medical Center Mullica Hill 700 Mullica Hill Rd. Mullica Hill NJ 08302 856-508-1000

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 by Inspira as part of this authorization. Initial Selections:

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 (42 CFR Part 2) which prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains or as otherwise permitted by such regulation.**

RECIPIENT (Name of person to whom Inspira Health 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:

□ Personal Use by Patient □ Send to other Health Care Provider □ Insurance Coverage □ Caregiver instruction □ Other (please specify):

AUTHORIZATION:

- I hereby authorize Inspira Health 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's Privacy Office at Inspira Health, 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 in reliance on this Authorization before it received my written notice of revocation.
- I understand that once Inspira Health 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; except, however, if my treatment at Inspira Health is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Inspira Health 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 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 signature:

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 must provide a copy of the signed Authorization form to the patient or representative.

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