



capitahealth

**Capital Health
Regional Medical Center**
750 Brunswick Avenue
Trenton, New Jersey 08638
609 394 6000

**Capital Health
Medical Center - Hopewell**
One Capital Way
Pennington, New Jersey 08534
609 303 4000

Capital Health - Hamilton
1445 Whitehorse-Mercerville Road
Hamilton, New Jersey 08619
609 588 5050

capitalhealth.org

Authorization for Patient Access/Release of Health Information

Patient Name:		Medical Record #:	
Date of Birth:		Phone #:	
Home Address:		City:	State: Zip:
1. Type of Request: I hereby request the following: <input type="checkbox"/> Access to review my original medical record <input type="checkbox"/> Release/Disclosure of my health information, as requested below <input type="checkbox"/> Request my medical records from another facility <i>Name of Facility:</i> _____			
2. Description of Information To Be Released: <i>(Check ALL that apply)</i> <input type="checkbox"/> Abstract* (defined below) <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> History and Physical <input type="checkbox"/> Operative Reports <input type="checkbox"/> Immunization Record <input type="checkbox"/> ER Record <input type="checkbox"/> Progress Notes <input type="checkbox"/> X-ray Reports <input type="checkbox"/> Outpatient Records <input type="checkbox"/> Consultation Reports <input type="checkbox"/> EKG/EEG <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Treatment Record <input type="checkbox"/> Labs <input type="checkbox"/> Other <i>(specify):</i> _____ Date of Service _____ <i>(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)</i>			
I understand that the specific information to be released may include reference to alcohol abuse, drug abuse, AIDS/HIV infection, sexually transmitted diseases, tuberculosis, and/or psychiatric conditions and the treatment of any of these disorders. If this information is documented in my medical record, I agree to the release of it.			
3. Disclose/Send Information To: <input type="checkbox"/> Myself <i>(the patient or authorized representative)</i> <input type="checkbox"/> To Organization/Individual below:			
Organization:		Individual Name:	
Street Address:		Phone #:	
City:	State:	Zip Code:	<input type="checkbox"/> Please Mail <input type="checkbox"/> Please prepare for pick-up
4. Purpose of Release: I authorize Capital Health to release my health information for the following specific purpose: _____			
5. Term/Expiration: I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by providing a written revocation to Capital Health, Health Information Management Department at the address listed below. This authorization will automatically expire twelve (12) months from the date listed below. <i>I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.</i>			
6. Fees: Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care.			

Signature of Patient or Patient's Representative

Date

Relationship to Patient

Witness Signature