

Authorization for Access/Release of Protected Health Information

Instructions: Please complete the form in its entirety and mail to the appropriate Capital Health address based upon the location of your medical records. If you are requesting hospital medical records, send this form to the attention of the Health Information Management Department. Medical records can be accessed via the patient portal at https://www.capitalhealth.org/myportal.

capitalhealth.org

capitahealth

Patient Name:			Medic		Nedical Record #:	
Last: First:	Middle:					
Date of Birth:	Social Security #: XXX-XX-			F	Phone #:	
					State: Zip:	
1. Type of Request: I hereby request the following (include specific dates of s Release/Disclosure of my health information, as requested below from: Capital Medical Center-Hopewell: Dates of Services			or date rar	Capital Health- Hamilton: Dates of Services: Physician Practice(s) Physician's Name(s)		
Capital Health Regional Medical Center: Dates of Services						
Capital Health at Deborah-ED: Dates of Services			Access to review my original medical records (on-site)			
Immunization Record Consultation Reports EKG Entire Medical Record (Refer to section # 6 Fees) Labs Open				istory and Physi KG/EEG perative Report: ther (<i>specify):</i>	Discharge Summary	
(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, and test results)						
I understand that the specific information to be released may include reference to alcohol/drug abuse (42 CFR Part 2), AIDS/HIV infection (NJSA 26:5C-8), venereal diseases (NJSA 26:4-41), tuberculosis (NJCA 8:57-5.17), genetic information (NJSA 10:5-47 & 48) and/or psychiatric conditions (NJSA 10:37-6:79) 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: Myself (the patient or authorized representative) To Organization/Individual below:						
Organization:	Individual Nar	ne:			Phone #:	
Street Address: City:		State:			Mail Kathering Mail	
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 Regional or Hopewell address listed. The revocation is effective upon receipt of my written notice, except that the revocation will not have any effect on any action by Capital Health in reliance on this Authorization before it received my written notice of revocation. This authorization automatically expires twelve (12) months from the date listed below. 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.						
6. Fees: Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care. I understand that Capital Health is permitted under state and federal laws to charge me a fee for photocopies or information provided digitally of my medical record. I further understand that under New Jersey law, the fees are based on actual costs and may not exceed \$1.00 per page or \$100.00 per record (for the first 100 pages) and \$0.25 per page thereafter up to a maximum of \$200.00 per encounter, for hospital encounters. The fee for physician practice records are a flat fee of \$10.00 (for the first 10 pages) and \$1.00 per page thereafter up to \$100.00.						
Signature of Dationt or Dationt's Depresentative						
Signature of Patient or Patient's Representative			Date			
Relationship to Patient		Witnes	Witness Signature			
Capital Health Regional Medical Center 750 Brunswick Avenue Trenton, New Jersey 08638 609 394 6000	□ Capital Hea One Capital W Pennington, No 609 303 4000	ay		r – Hopewe	II □ Capital Health – Hamilton 1445 Whitehorse-Mercerville Road Hamilton, New Jersey 08619 609 588 5050	