



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  
609.303.5050

## 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 please 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>.

Patient Name: Last: _____ First: _____ Middle: _____		Medical Record #:																	
Date of Birth: _____		Social Security #: XXX-XX- _____																	
Home Address: _____		City: _____ State: _____ Zip: _____																	
<b>1. Type of Request:</b> I hereby request the following (include specific dates of service(s) or date range): <input type="checkbox"/> Release/Disclosure of my health information, as requested below from: <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> Capital Medical Center-Hopewell: Dates of Services _____</td> <td style="width:50%; border:none;"><input type="checkbox"/> Capital Health- Hamilton: Dates of Services: _____</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Capital Health Regional Medical Center: Dates of Services _____</td> <td style="border:none;"><input type="checkbox"/> Physician Practice(s) _____</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Capital Health at Deborah-ED: Dates of Services _____</td> <td style="border:none;"><input type="checkbox"/> Physician's Name(s) _____</td> </tr> <tr> <td style="border:none;"></td> <td style="border:none;"><input type="checkbox"/> Access to review my original medical records (on-site)</td> </tr> </table>				<input type="checkbox"/> Capital Medical Center-Hopewell: Dates of Services _____	<input type="checkbox"/> Capital Health- Hamilton: Dates of Services: _____	<input type="checkbox"/> Capital Health Regional Medical Center: Dates of Services _____	<input type="checkbox"/> Physician Practice(s) _____	<input type="checkbox"/> Capital Health at Deborah-ED: Dates of Services _____	<input type="checkbox"/> Physician's Name(s) _____		<input type="checkbox"/> Access to review my original medical records (on-site)								
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	<input type="checkbox"/> Access to review my original medical records (on-site)																		
<b>2. Description of Information To Be Released:</b> (Check ALL that apply) <table style="width:100%; border:none;"> <tr> <td style="width:25%; border:none;"><input type="checkbox"/> Abstract*</td> <td style="width:25%; border:none;"><input type="checkbox"/> ER Record</td> <td style="width:25%; border:none;"><input type="checkbox"/> History and Physical</td> <td style="width:25%; border:none;"><input type="checkbox"/> X-ray Reports</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Immunization Record</td> <td style="border:none;"><input type="checkbox"/> Consultation Reports</td> <td style="border:none;"><input type="checkbox"/> EKG/EEG</td> <td style="border:none;"><input type="checkbox"/> Discharge Summary</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Entire Medical Record (Refer to section # 6 Fees)</td> <td style="border:none;"><input type="checkbox"/> Labs</td> <td style="border:none;"><input type="checkbox"/> Operative Reports</td> <td style="border:none;"></td> </tr> <tr> <td colspan="4" style="border:none;"><input type="checkbox"/> Other (specify): _____</td> </tr> </table> <p>(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, and test results)</p>				<input type="checkbox"/> Abstract*	<input type="checkbox"/> ER Record	<input type="checkbox"/> History and Physical	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> EKG/EEG	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Entire Medical Record (Refer to section # 6 Fees)	<input type="checkbox"/> Labs	<input type="checkbox"/> Operative Reports		<input type="checkbox"/> Other (specify): _____			
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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.																			
<b>3. Disclose/Send Information To:</b> <input type="checkbox"/> Myself (the patient or authorized representative) <input type="checkbox"/> To Organization/Individual below:																			
Organization: _____		Individual Name: _____																	
Street Address: _____		Phone #: _____																	
City: _____		<input type="checkbox"/> Email _____ <input type="checkbox"/> Mail _____ <input type="checkbox"/> Fax# to physician practice _____																	
State: _____		<input type="checkbox"/> Prepare for pick-up <input type="checkbox"/> Other _____																	
Zip Code: _____																			
<b>4. Purpose of Release:</b> I authorize Capital Health to release my health information for the following specific purpose: _____																			
<b>5. Term/Expiration:</b> 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 above. The revocation will be 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 will automatically expire 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.																			
<b>6. Fees:</b> 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.																			
<b>7. Acknowledgment:</b> By completing this form, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of email between Capital Health and me, and consent to the conditions outlined herein, as well as any other instructions that Capital Health may impose to communicate with me by email. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization. Capital Health will have a limited capacity to read emails sent from patients and you should not use email to communicate with Capital Health after receiving your medical records. If you need to speak to your provider concerning your medical records, please contact your provider directly. This authorization is contingent upon review and approval by the Health Information Management Department.																			

Signature of Patient or Patient's Representative

Date

Relationship to Patient

Witness Signature