☐ 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 Access/Release of Protected Health Information, Side 1 of 2

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.

If you are any of these entities, please complete the front and back side of this form, regardless if your request is related to reproductive health records or not:
Law Enforcement ___ Coroners' Office/Medical Examiner ___ Health oversight activities ___
Judicial/Administrative Proceeding ___

Patient Name: Last: First: Middle:		Medical Record #:
Date of Birth:	Social Security #: XXX-XX-_____	Phone #:
Home Address: City: State: Zip:		
Would you like to obtain access to the hospital portal (only for patients over the age of 18)?_____Yes____No		

1. Type of Request: I hereby request the following (include specific dates of service(s) or date range):

Release/Disclosure of my health information, as requested below from:

- ☐ Capital Health Medical Center-Hopewell: Dates of Services_____
- ☐ Capital Health Regional Medical Center: Dates of Services_____
- ☐ Capital Health Deborah-ED: Date of Services_____
- ☐ Capital Health-East Trenton: Date of Services:_____
- ☐ Capital Health-Hamilton: Dates of Services: _____
- ☐ Capital Health-EMS: Dates of Services: _____
- ☐ Capital Health Medical Group
  - Physician's Practice(s)/Name_____
  - Dates of Services:_____
- ☐ St. Francis Medical Center: Dates of Services: _____
- ☐ St. Francis Medical Associates
  - Physician's Practice(s)_____
  - Physician's Name(s)_____
  - Dates of Services: _____
- ☐ Access to review my original medical records (on- site):_____
- ☐ Capital Health LIFE _____
- ☐ Access to review my original medical records (on- site):_____
- ☐ Other (specify location):_____

2. Description of Information To Be Released: *(Check ALL that apply)*

- ☐ Abstract*
- ☐ Immunization Record
- ☐ Entire Medical Record
- ☐ ER Record
- ☐ Consultation Reports
- ☐ Labs
- ☐ History and Physical
- ☐ EKG/EEG
- ☐ Operative Reports
- ☐ X-ray Reports
- ☐ Discharge Summary
- ☐ Reproductive Health
- ☐ Other (specify): _____

*(*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 Name:	Phone #:
Street Address:	City:	☐ Email _____ ☐ Prepare for pick-up ☐ Other _____
State:	Zip Code:	☐ Mail ☐ Fax# to physician practice: _____

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 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.*

6. Acknowledgment:
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 and/or Authorized Requester

_____ Date

_____ Relationship to Patient

_____ Witness Signature

Attestation Regarding a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care, Side 2 of 2

The entire form must be completed for the attestation to be valid.

Name of person(s) or specific identification of the class of persons to receive the requested Protected Health Information (PHI). e.g., name of investigator and/or agency making the request:

_____
_____
_____

Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure: e.g., name of Covered Entity or Business Associate that maintains the PHI and/or name of their workforce member who handles requests for PHI:

_____
_____
_____

Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose Protected Health Information you are requesting.

_____
_____
_____

Please check the below boxes, if applicable, for the records you are requesting.

☐ Visit summary for [name of individual] _____on _____

☐ List of individuals who obtained a specific medication:

_____

☐ Please include specific name of prescription and date range:

_____

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of Protected Health Information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ *The purpose of the use or disclosure of Protected Health Information is to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided. I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

- [For internal purposes only: if the above *box is selected, please stop release process, and refer the request to the Risk Management department].

By signing this attestation, you are verifying that you are not requesting PHI for a prohibited purpose and acknowledging that criminal penalties may apply if untrue. You may not add content that is not required or combine this form with another document except where another document is needed to support your statement that the requested disclosure is not for a prohibited purpose. For example, if the requested PHI is potentially related to reproductive health care that was provided by someone other than Capital Health from whom you are requesting the PHI, you may submit a document that supplies information that demonstrates a substantial factual basis that the reproductive health care in question was not lawful under the specific circumstances in which it was provided.

_____ _____

Signature of Requester Date