

# CARRIER CLINIC

P.O. Box 147

Belle Mead, New Jersey 08502

Fax 1-908-281-1671

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (print): \_\_\_\_\_ Patient Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_ authorize \_\_\_\_\_  
to disclose my PHI (Protected Health Information), to the extent and nature indicated below, to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
Telephone # \_\_\_\_\_  
Secured Fax # \_\_\_\_\_

For the purpose of: \_\_\_\_\_

Dates of treatment, if known: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

### Check each item that applies:

- Verbal communication (*Limited to:*) \_\_\_\_\_
- Psychiatric Admission Evaluation and Social Assessment
- Physical Examination, laboratory tests and consultation
- Psychological testing/learning disability evaluation
- Progress Notes
- Discharge Summary
- Master Treatment Plan
- Patient Discharge Instructions
- ECT Records
- Completion of disability forms
- Photographic Image
- Records from other facilities
- Letter with admission & discharge dates
- Other (please specify) \_\_\_\_\_

By initialing this release, I also consent to the release of any information in my file pertaining to my alcohol/substance abuse.

Please initial here: \_\_\_\_\_

By initialing this release, I also consent to the release of any information in my file pertaining to my HIV status, the presence of AIDS antibodies or antigens.

Please initial here: \_\_\_\_\_

I hereby  authorize  do not authorize \_\_\_\_\_ to FAX certain information from my medical record(s) to the extent and nature indicated above. I understand the risks related to patient confidentiality inherent in the use of this technology (i.e., information may not reach the person for whom it is intended, or, may reach someone else for whom it was not intended.) Despite this risk, I request that my medical record information be transmitted in the manner in the specific instance indicated.

Any information disclosed which is protected under Federal confidentiality rules (42 CFR Part 2) will be treated as specified by such rules. I understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent will expire one (1) year from the date of this signature. I understand that information disclosed under this authorization may be re-disclosed by the recipient and in case of such re-disclosure the information may not be protected by federal privacy laws or regulations. I am signing this authorization voluntarily and understand that my receipt of healthcare treatment is not contingent upon complying with this request for authorization. This authorization is limited to information contained in my medical record and does not include psychotherapy notes. If needed, a separate authorization is required to disclose psychotherapy notes.

Signed \_\_\_\_\_  
(Patient – age 14 or over)

Date \_\_\_\_\_

(Parent or Guardian of Minor) or (Other person authorized to sign in lieu of patient. A copy of such authorization must accompany this consent.)

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

# How to Complete a Proper Authorization - Do not complete this side.

## CARRIER CLINIC

P.O. Box 147  
Belle Mead, New Jersey 08502  
Phone: 908-281-1000 Fax: 908-281-1671

### AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (print): \_\_\_\_\_ Patient Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_ authorize \_\_\_\_\_ to disclose my PHI (Protected Health Information), to the extent and nature indicated below, to the following:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Secured Fax #: \_\_\_\_\_

Write requestor's name, address, phone # check for secured fax #

Write Carrier Clinic or other facility name in this field

For the purpose of: \_\_\_\_\_

Dates of treatment, if known: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Specify specific dates of Tx or time period

Check each item that applies:

- Verbal communication (Limited to): \_\_\_\_\_
- Psychiatric Admission Evaluation and Social Assessment
- Physical Examination, laboratory tests and consultation
- Psychological testing/learning disability evaluation
- Progress Notes
- Discharge Summary
- Master Treatment Plan
- Patient Discharge Instructions
- ECT and Other Treatments
- Completion of disability forms
- Photographic Image
- Letter with admission & discharge dates
- Other (please specify) \_\_\_\_\_

Check only specific items for release. Do not check all.

By initialing this release, I also consent to the release of any information in my file pertaining to my alcohol/substance abuse.

Please initial here: \_\_\_\_\_

Patient must check these areas if appropriate

By initialing this release, I also consent to the release of any information in my file pertaining to my HIV status, the presence of AIDS antibodies or antigens.

Please initial here: \_\_\_\_\_

Check only if info will be faxed

I hereby  authorize  do not authorize \_\_\_\_\_ to FAX certain information from my medical record(s) to the extent and nature indicated above. I understand the risks related to patient confidentiality inherent in the use of this technology (i.e., information may not reach the person for whom it is intended, or, may reach someone else for whom it was not intended.) Despite this risk, I request that my medical record information be transmitted in the manner in the specific instance indicated.

Any information disclosed which is protected under Federal confidentiality rules (42 CFR Part 2) will be treated as specified by such rules. I understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. The consent will expire one (1) year from the date of this signature. I understand that information disclosed under this authorization may be re-disclosed by the recipient and in case of such re-disclosure the information may not be protected by federal privacy laws or regulations. I am signing this authorization voluntarily and understand that my receipt of healthcare treatment is not contingent upon complying with this request for authorization. This authorization is limited to information contained in my medical record and does not include psychotherapy notes. If needed, a separate authorization is required to disclose psychotherapy notes.

Signed \_\_\_\_\_  
(Patient - age 14 or over)

Date \_\_\_\_\_

(Parent or Guardian of Minor) or (Other person authorized to sign in lieu of patient.  
A copy of such authorization must accompany this consent.)

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

ALL APPROPRIATE BLANKS MUST BE COMPLETED BEFORE INFORMATION WILL BE RELEASED.

CC-Authorization for Disclosure of Health Information 123 (Rev 4/21/08, 08 SML, 9/1/08, 1/22/10)

**Please remember all PHI sent from Carrier Clinic must be sent to a secured fax machine**