Name:
Unit #:
MRN #:

RUTGERS
University Behavioral
Health Care

AUTHORIZATION TO RELEASE AND OBTAIN PROTECTED HEALTH INFORMATION

_____ _____ _____
Client/Consumer/Patient Name Date of Birth Telephone Number

I hereby authorize University Behavioral Health Care to: (Please check)

_____ release my protected health information as indicated below TO: **OR** _____ *obtain my protected health information FROM:

_____ discuss my protected health information WITH:

_____ _____
Name of Individual and/or Organization Telephone Number

_____ _____
Address E-Mail Address/ Fax # (if applicable)

*For protected health information authorized to be disclosed to UBHC, please send to the attention of the following UBHC Staff and/or Program:

_____

Information to be disclosed/released: (Please check)

____ Term/Transfer/Disch Summary ____ Evaluation _____ Treatment Plan ____ Diagnosis/Problem List ____ Progress Note ____ Lab Test

____ Urine Drug Screen ____ Medication List ___ Letter(s)/Form(s) Other:_____

I understand that this authorization includes permission to discuss and/or release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, DNA Test Results/genetic information, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV). If you wish not to disclose any of the above information, you must indicate below. Otherwise, this information will be released.

Do not release the following: _____

_____ _____
Purpose of Disclosure (ie. Individual Request, Disability, Attorney, School, etc.) Approximate Dates of Treatment

If not previously revoked, this authorization will expire four (4) months from the date signed or as otherwise specified below (up to one yr):

_____

1. I understand that this authorization may be revoked at any time by submitting a completed Revocation of Authorization form to the Health Information Management Department, except to the extent that UBHC has already taken action in reliance on this authorization.
2. I understand that my alcohol and drug treatment records are protected under federal regulations 42 CFR part 2 and HIPAA 45 CFR parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Persons receiving confidential information may not further disclose such information if the information includes drug or alcohol use or treatment.
3. I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that my signing this form waives this privilege.
4. I acknowledge and understand that uses and disclosures of my information may be subject to re-disclosure by the recipient and may not be protected by federal privacy laws.
5. I understand that UBHC will not make decisions concerning treatment, payment, enrollment, or eligibility for benefits based on signing, refusing to sign, or revoking this authorization.
6. A photocopy or fax and DocuSigned copy of this form is as valid as the original.

_____ _____/_____/_____
Signature of Client/Consumer/Patient (If 14 years or older, must sign for self) Date Signed

_____ _____/_____/_____
Signature of Parent, Guardian, or Authorized Representative Date Signed