



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____
(First, Middle, Last)

Address: _____ Phone Number: _____
(Number, Street, City, State, Zip Code)

Indicate which Virtua Health location you are requesting medical records from by checking the appropriate box below. Submit your completed Authorization in person or by mail to the address provided for that location.

Check Below	Name of Virtua Location to Release Your PHI	Location Address
<input type="checkbox"/>	Virtua Marlton Hospital	HIM/Medical Record Department 90 Brick Road, Marlton, NJ 08053
<input type="checkbox"/>	Virtua Memorial Hospital	HIM/Medical Record Department 175 Madison Avenue, Mt. Holly, NJ 08060
<input type="checkbox"/>	Virtua Voorhees Hospital	HIM/Medical Record Department 100 Bowman Drive, Voorhees, NJ 08043
<input type="checkbox"/>	Virtua Our Lady of Lourdes Hospital	HIM/Medical Record Department 1600 Haddon Avenue, Camden, NJ 08103
<input type="checkbox"/>	Virtua Willingboro Hospital	HIM/Medical Record Department 218 A Sunset Road, Willingboro, NJ 08046
<input type="checkbox"/>	Virtua Health & Wellness Center - Camden	HIM/ Medical Record Department 1000 Atlantic Avenue, Camden NJ 08104
<input type="checkbox"/>	Virtua Health & Wellness Center – Berlin	HIM/ Medical Record Department 100 Townsend Avenue, Berlin NJ 08009
<input type="checkbox"/>	Virtua Home Care – Mount Laurel	523 Fellowship Road, Suite 250 Mt. Laurel, NJ 08054
<input type="checkbox"/>	Virtua Samson Cancer Center	HIM/Medical Record Department 350 Young Avenue Moorestown, NJ 08057
<input type="checkbox"/>	Virtua Rehabilitation Center – Mount Holly	HIM/Medical Record Department 62 Richmond Avenue, Lumberton NJ 08048
<input type="checkbox"/>	Virtua Rehabilitation Center – Berlin	HIM/Medical Record Department 100 Long-A-Coming Lane, Berlin NJ 08009
<input type="checkbox"/>	Other (list location name):	Submit Authorization to Address of Specified Location.

Purpose of the Requested Release of PHI:

At my request Continuity of Care Legal Insurance Other (explain): _____

Description of PHI to be Released:

Emergency Dept. records (not admitted) for the following date(s): _____

Same Day / Outpatient Surgery records for the following date(s): _____

Inpatient Admission records for the following date(s): _____



Home Care records for the following date(s): _____

Long Term Care records for the following date(s): _____

Outpatient records for the following date(s): _____

- Specify the outpatient departments you are requesting records from:

X-ray Physical Therapy Cardiovascular Lab Physician's Office Other _____

	 RELEASE OF PATIENT INFORMATION FROM A VIRTUA FACILITY
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PATIENT NAME: _____

DATE OF BIRTH: _____

Specific Reports to be Released:

- Operative Report(s)
- Discharge Summary
- Emergency Report
- History & Physical
- Other (*describe*): _____
- Laboratory
- Pathology Report(s)
- Radiology/Nuclear Medicine
- EKG / Cardiology
- Consultation(s)
- Provider Orders
- Provider Progress Notes
- Vascular Studies

Release PHI to:

Name of Person or Institution: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Email: _____

Authorization

I hereby authorize Virtua to disclose the health information as described above. I understand that such disclosure may include information of a more sensitive nature, such as records related to: mental or behavioral health, substance use disorder (drug or alcohol abuse), genetic diseases or testing, sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and birth control and abortion (family planning). I specifically authorize the disclosure of such sensitive health information to the person or institution noted above.

I understand that my authorization will automatically expire six (6) months from the date of signature on this form. I understand that I have a right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and submit my written revocation to the Health Information Management (Medical Records) Department at the Virtua location noted above. I understand that the revocation will not apply to health information that has already been disclosed in response to this authorization.

I understand that this authorization shall operate as a complete release of liability to the Virtua location(s) specified above, and its trustees, officers, employees, and agents, for the disclosure of the health information as described above.

I understand that the health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and/or state law.

Signing this authorization is voluntary and I understand that Virtua may not condition treatment, payment, enrollment or eligibility for benefits on my signing or refusal to sign this authorization.

By signing below, I understand that I am authorizing Virtua to disclose the health information as describe above.

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Signature of Patient or Patient’s Legal Representative (as applicable)

Date

Time

Name of Patient’s Legal Representative (Print)

Relationship to Patient or Statement of Authority to act on Patient’s Behalf (i.e. spouse, parent, legal guardian, person acting *in loco parentis*, etc.)

Note to Recipient of Information (as applicable): This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65