



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 corresponding box below. Submit your completed Authorization in person or by mail to the address provided for that location.

CHECK BELOW	VIRTUA SITE	ADDRESS
<input type="checkbox"/>	Virtua Marlton Hospital	HIM/Medical Records Department 90 Brick Road, Marlton, NJ 08053
<input type="checkbox"/>	Virtua Mount Holly Hospital	HIM/Medical Records Department 175 Madison Avenue, Mt. Holly, NJ 08060
<input type="checkbox"/>	Virtua Voorhees Hospital	HIM/Medical Records Department 100 Bowman Drive, Voorhees, NJ 08043
<input type="checkbox"/>	Virtua Our Lady of Lourdes Hospital	HIM/Medical Records Department 1600 Haddon Avenue, Camden, NJ 08103
<input type="checkbox"/>	Virtua Willingboro Hospital	HIM/Medical Records Department 218 A Sunset Road, Willingboro, NJ 08046
<input type="checkbox"/>	Virtua Health & Wellness Center – Camden	HIM/Medical Records Department 1000 Atlantic Avenue, Camden, NJ 08104
<input type="checkbox"/>	Virtua Health & Wellness Center – Berlin	HIM/Medical Records Department 100 Townsend Avenue, Berlin, NJ 08009
<input type="checkbox"/>	Virtua Home Care	523 Fellowship Road, Suite 250, Mount Laurel, NJ 08054
<input type="checkbox"/>	Virtua Samson Cancer Center	HIM/Medical Records Department 350 Young Avenue, Moorestown, NJ 08057
<input type="checkbox"/>	Other (list location name):	Submit Authorization to address of specified location. <i>*If the request for records relates to records from former Virtua Rehabilitation Centers (Mount Holly or Berlin), please submit your request to: HIM/Medical Record Department – 100 Bowman Drive, Voorhees NJ 08043.</i>

Purpose of the Disclosure of PHI:

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

Description of the PHI to be Disclosed:

- Emergency Department 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 _____

Specific Record Types to be Disclosed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Consultation(s) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Provider Orders |
| <input type="checkbox"/> Emergency Report | <input type="checkbox"/> Radiology/Nuclear Medicine | <input type="checkbox"/> Provider Notes |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> EKG / Cardiology | <input type="checkbox"/> All Records |
| <input type="checkbox"/> Other (describe): _____ | | |

	RELEASE OF PATIENT INFORMATION FROM A VIRTUA FACILITY
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