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
	Virtua Marlton Hospital	HIM/Medical Records Department 90 Brick Road, Marlton, NJ 08053
	Virtua Mount Holly Hospital	HIM/Medical Records Department 175 Madison Avenue, Mt. Holly, NJ 08060
	Virtua Voorhees Hospital	HIM/Medical Records Department 100 Bowman Drive, Voorhees, NJ 08043
	Virtua Our Lady of Lourdes Hospital	HIM/Medical Records Department 1600 Haddon Avenue, Camden, NJ 08103
	Virtua Willingboro Hospital	HIM/Medical Records Department 218 A Sunset Road, Willingboro, NJ 08046
	Virtua Health & Wellness Center – Camden	HIM/Medical Records Department 1000 Atlantic Avenue, Camden NJ 08104
	Virtua Health & Wellness Center – Berlin	HIM/Medical Records Department 100 Townsend Avenue, Berlin NJ 08009
	Virtua Home Care	523 Fellowship Road, Suite 250, Mount Laurel, NJ 08054
	Virtua Samson Cancer Center	HIM/Medical Records Department 350 Young Avenue Moorestown, NJ 08057
	Other (*list location name*):	Submit Authorization to address of specified location. **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.*

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:

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

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Disclose the PHI to:

Name of Person or Institution: Records Deposition Service

Address: P.O. Box 5054

City/State/Zip: Southfield, MI 48086-5054

Phone Number: (248) 357-3330 Email: requests@recdep.com F (248) 357-3337

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 reproductive health care services, including, but not limited to, pregnancy, contraception, and termination or loss of pregnancy. I specifically authorize the disclosure of such sensitive health information to the person or institution noted above, including information protected by 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records), understanding that substance use disorder records are subject to special federal confidentiality protections.

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. However, I understand that records concerning substance use disorder treatment that are protected by 42 CFR Part 2 may not be redisclosed by the recipient without my specific written consent or as otherwise permitted by 42 CFR Part 2, and that a general authorization for release of medical information is NOT sufficient to permit redisclosure of substance use disorder information.

Signing this authorization is voluntary and I understand that the facility or institution listed in Section 1 above 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 the facility or institution listed in Section 1 above to disclose the health information as described above.

_____ _____ _____

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: To the extent that the records disclosed to you pursuant to this Authorization contain information protected by 42 CFR Part 2 (the federal regulations governing Confidentiality of Substance Use Disorder Patient Records), you are hereby notified that 42 CFR Part 2 prohibits you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2; (ii) you are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) you have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31)