



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO THE
BARNABAS HEALTH MEDICAL GROUP PRACTICE OF NEW JERSEY CARDIOLOGY ASSOCIATES

PATIENT NAME _____ DOB _____

SOCIAL SECURITY NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

I hereby authorize _____

To disclose my health information to the Barnabas Health Medical Group practice of New Jersey Cardiology Associates

The information to be disclosed to and used by the above is for the following purpose: _____

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

Information to be disclosed:

- Emergency Room Record, History & Physical Exam, Operative Reports & Pathology, Discharge Summary, Consultations, Progress notes, Labs, Xrays & Tests, Nurses' Notes, Email Correspondence, Complete Record, Abstract, Billing Information, Other

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS< SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, and email correspondence as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Barnabas Health Medical Group practice of New Jersey Cardiology Associates.

I understand that this revocation will not apply to the extent of any actions that the practice has already taken in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Barnabas Health Medical Group practice of New Jersey Cardiology Associates at 973-731-9442

PATIENT SIGNATURE: _____ DATE _____

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE: _____ DATE _____

RELATIONSHIP: _____

WITNESS: _____ DATE _____

(Two signatures required for verbal consent)

ORIGINAL - MAIL TO DISCLOSING PROVIDER

COPY - RECORD

COPY - PATIENT