RWJMG-EOHSI
170 Frelinghuysen Road Piscataway, NJ 08854
Phone: 848-445-0123

For: **DOB** **MRN:**

RUTGERS
Robert Wood Johnson Medical School

Monitoring and Treatment 9/11 WTC Health Program

Authorization for Release of Protected Health Information

I understand that, by completing the box(es) below, if my Protected Health Information contains information related to the history, diagnosis and/or treatment of any of the listed situations, that my signing this document authorizes The Rutgers – Robert Wood Johnson Medical Group to release that information. I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege. Checking either the DNA or the Genetic Information box indicates that I believe my records may contain DNA test results or other genetic information. Such information is specially protected by New Jersey law, and I will be contacted for separate specific consent prior to release of this information.

I authorize the The Rutgers- Robert Wood Johnson Medical Group to disclose my protected health information to the following extent:

(There may be a charge for providing copies)

	Medical Record	Billing Record
Specific Treatment Dates(indicate to/from date in box at right)		
Specific Practice/Physician(indicate name in box at right)		
Specific Medical Forms(indicate form in box at right or attach copy of form to be completed and check box at right)		
Entire Content of Record(please check box(es) at right)		

If the record requested above contains any of the following information, you must check the boxes below to authorize release of the specific information. If you **Do Not** check the boxes, any information related to the boxes below contained in the requested record will not be released.

__ **Psychiatric Problems** __ **Mental Illness** __ **Drug Abuse** __ **Alcoholis** __ **HIV/AID** __ **Communicable Diseases**

__ **Sexually Transmitted Disease** __ **Test for Infection with HIV** __ **Genetic Information** __ **DNA Test Results**_____**(specify name of test)**

Indicate the name and address where the requested records are to be sent:

Name_____

Address_____

Phone Number_____

This consent may be revoked at any time by writing to the Rutgers- Robert Wood Johnson Medical School, Privacy Officer at Liberty Plaza- 335 George St. Suite 3302, New Brunswick, New Jersey 08901, except to the extent that the Rutgers- Robert Wood Johnson Medical School, has already taken action in reliance on this authorization. If not previously revoked, this consent will terminate upon_____. (indicate date or expiration event, i.e. upon mailing) The Rutgers- Robert Wood Johnson Medical School, will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

I acknowledge and understand that uses and disclosures of my protected health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws.

Signature of Patient or Legal Representative:_____ Date: _____

Print Name:_____Relationship to Patient:_____(attach copy of proof of legal relationship, if applicable)