HAMPTON BEHAVIORAL HEALTH CENTER
650 Rancocas Road, Westampton, NJ 08060

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

PATIENT NAME:_____ DATE OF BIRTH:_____

DATE(S) OF ADMISSION:_____ SOCIAL SECURITY#:_____

I hereby authorize Hampton Behavioral Health Center to _____release or _____obtain information by mail, courier or facsimile (fax) transmittal to/from:

PERSON OR ORGANIZATION:_____
_____
(PLEASE PRINT)

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

FOR THE PURPOSE OF:_____

The following information is to be disclosed:

☐Inpatient Discharge Summary	☐Consultations	☐Outpatient Discharge Summary
☐Integrated Assessment	☐Telephone Contact	☐Outpatient Psychiatric Assessment
☐History & Physical Examination	☐Medication Profile Summary	☐Outpatient Clinical Assessment
☐Lab Tests/X-rays	☐Complete Chart Copy	☐Letter to State Dates of Treatment
☐Other:_____		

NOTICE TO PATIENT AND RECIPIENT OF RECORDS

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal and NJ State Law and interpretive guidelines promulgated thereunder. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and New Jersey State Law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have been informed and understand that this authorization is subject to revocation by me at any time except to the extent that Hampton Behavioral Health Center has already taken action in reliance on it. If I do not revoke this authorization it will automatically expire 60 days from the date of signature unless otherwise noted below. Once the requested protected health information is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient rediscloses it. I understand that treatment or payment for treatment are not conditioned on signing the authorization. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Hampton Behavioral Health Center from all liability should this information be received by someone other than the above-intended recipient. I further understand that the information disclosed **may** include psychiatric, drug/alcohol abuse and/or HIV data.

This consent is effective beginning on_____, and expires on_____, if not earlier revoked.

_____

PATIENT'S SIGNATURE (Ages 14 and Older) DATE

_____

PARENT/LEGAL GUARDIAN SIGNATURE DATE

WITNESS SIGNATURE DATE