

**HAMPTON BEHAVIORAL HEALTH CENTER**  
650 Rancocas Road, Westampton, NJ 08060  
**AUTHORIZATION TO RELEASE/OBTAIN  
MEDICAL RECORDS**

PATIENT NAME: \_\_\_\_\_  
DATE(S) OF ADMISSION: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_  
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: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

FOR THE PURPOSE OF: \_\_\_\_\_

The following information is to be disclosed: (Check all items to be released)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Inpatient Discharge Summary  | <input type="checkbox"/> Consultations              | <input type="checkbox"/> Outpatient Discharge Summary       |
| <input type="checkbox"/> Multidisciplinary Assessments  | <input type="checkbox"/> Telephone Contact          | <input type="checkbox"/> Outpatient Psychiatric Assessment  |
| <input type="checkbox"/> History & Physical Examination   | <input type="checkbox"/> Medication Profile Summary | <input type="checkbox"/> Outpatient Clinical Assessment     |
| <input type="checkbox"/> Lab Tests/X-rays   | <input type="checkbox"/> Complete Chart Copy        | <input type="checkbox"/> Letter to State Dates of Treatment |
| <input type="checkbox"/> Transition Record (Fax Cover Sheet, Discharge Plan, After Care, Discharge Medications, Safety Plan, Advance Directive Acknowledgement) |   |   |
| <input type="checkbox"/> 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) and New Jersey State Law. 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