capitalhealth
Minds Advancing Medicine

Center for Digestive Health
2 Capital Way
Suite 380
Pennington, NJ 08534

Authorization for Patient Access/Release of Health Information

Patient Name:		Medical Record #:	
Date of Birth:		Phone #:	
Home Address:	City:	State:	Zip:

1. Type of Request: I hereby request the following:

☐	Access to review my original medical record	☐	Release/Disclosure of my health information, as requested below
☐	Request my medical records from another facility	*Name of Facility:*	

2. Description of Information To Be Released: *(Check ALL that apply)*

☐	Abstract* (defined below)	☐	Entire Medical Record	☐	History and Physical	☐	Operative Reports
☐	Immunization Record	☐	ER Record	☐	Progress Notes	☐	X-ray Reports
☐	Outpatient Records	☐	Consultation Reports	☐	EKG/EEG	☐	Discharge Summary
☐	Treatment Record	☐	Labs	☐	Other (*specify):*	☐	

Date of Service				

*(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)*

I understand that the specific information to be released may include reference to alcohol abuse, drug abuse, AIDS/HIV infection, sexually transmitted diseases, tuberculosis, and/or psychiatric conditions and the treatment of any of these disorders. If this information is documented in my medical record, I agree to the release of it.

3. Disclose/Send Information To:

☐	Myself *(the patient or authorized representative)*	☐	To Organization/Individual below:

Organization:	Individual Name:			Phone #:
Street Address: City:		State:	Zip Code:	☐ Please Mail ☐ Please prepare for pick-up

4. Purpose of Release: I authorize Capital Health to release my health information for the following specific purpose:

5. Term/Expiration:
I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by providing a written revocation to Capital Health, Health Information Management Department at either campus. This authorization will automatically expire twelve (12) months from the date listed below. *I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.*

6. Fees:
Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care.

Signature of Patient or Patient's Representative Date

Relationship to Patient Witness Signature