☐ Capital Health
Regional Medical Center
750 Brunswick Avenue
Trenton, New Jersey 08638
609 394 6000

☐ Capital Health
Medical Center - Hopewell
One Capital Way
Pennington, New Jersey 08534
609 303 4000

☐ Capital Health - Hamilton
1445 Whitehorse-Mercerville Road
Hamilton, New Jersey 08619
609 588 5050

capitalhealth.org

Authorization for Access/Release of Protected Health Information

Instructions: Please complete the form in its entirety and mail to the appropriate Capital Health address based upon the location of your medical records. If you are requesting hospital medical records please send this form to the attention of the Health Information Management Department. Medical records can be accessed via the patient portal at https://www.capitalhealth.org/myportal.

Patient Name: Last: First: Middle:		Medical Record #:
Date of Birth:	Social Security #: XXX-XX-_____	Phone #:
Home Address: City: State: Zip:		

Would you like to obtain access to the hospital portal (only for patients over the age of 18)?_____Yes____No

1. Type of Request: I hereby request the following (include specific dates of service(s) or date range):

☐ Release/Disclosure of my health information, as requested below from:

- ☐ Capital Health Medical Center-Hopewell: Dates of Services_____
- ☐ Capital Health Regional Medical Center: Dates of Services_____
- ☐ Capital Health Deborah-ED: Date of Services_____
- ☐ Capital Health-East Trenton: Date of Services:_____
- ☐ Capital Health-Hamilton: Dates of Services: _____
- ☐ Capital Health-EMS: Dates of Services: _____
- ☐ Capital Health Medical Group
  - Physician's Practice(s)_____
  - Physician's Name(s)_____
  - Dates of Services:_____
- ☐ St. Francis Medical Center: Dates of Services: _____
- ☐ St. Francis Medical Associates
  - Physician's Practice(s)_____
  - Physician's Name(s)_____
  - Dates of Services: _____
- ☐ Access to review my original medical records (on- site):_____

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

☐ Abstract*	☐ ER Record	☐ History and Physical	☐ X-ray Reports
☐ Immunization Record	☐ Consultation Reports	☐ EKG/EEG	☐ Discharge Summary
☐ Entire Medical Record	☐ Labs	☐ Operative Reports	☐ Reproductive Health
		☐ Other (specify): _____	

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

I understand that the specific information to be released may include reference to alcohol/drug abuse (42 CFR Part 2), AIDS/HIV infection (NJSA 26:5C-8), venereal diseases (NJSA 26:4-41), tuberculosis (NJCA 8:57-5.17), genetic information (NJSA 10:5-47 & 48) and/or psychiatric conditions (NJSA 10:37-6:79) 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:	☐ Email _____	☐ Prepare for pick-up ☐ Other _____
State:	Zip Code:	☐ Mail ☐ Fax# to physician practice _____	

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 the Regional or Hopewell address listed above. The revocation will be effective upon receipt of my written notice, except that the revocation will not have any effect on any action by Capital Health in reliance on this Authorization before it received my written notice of revocation. 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. Acknowledgment:

By completing this form, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of email between Capital Health and me, and consent to the conditions outlined herein, as well as any other instructions that Capital Health may impose to communicate with me by email. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.

Capital Health will have a limited capacity to read emails sent from patients and you should not use email to communicate with Capital Health after receiving your medical records. If you need to speak to your provider concerning your medical records, please contact your provider directly.

This authorization is contingent upon review and approval by the Health Information Management Department.

Signature of Patient or Patient's Representative Date

Relationship to Patient Witness Signature