inspira HEALTH NETWORK

Authorization to Disclose Protected Health Information

Patient's Name Last	First	Middle
Home Address		
City	**State**	**Zip**
Home Telephone	**Date of Birth**	

Specify Information to be Disclosed: ☐ Entire Record

Service Date(s) or Range:_____

☐ Discharge Summary	☐ Operative Report	☐ Lab Reports	☐ Radiology Images
☐ Discharge Instructions	☐ ER Record	☐ EKG/ECG Tests	☐ Medication Records
☐ History and Physical	☐ X-Ray Reports	☐ Progress Notes	☐ Physician Orders
☐ Consultations	☐ Other (please specify):		

Please Check All Applicable Locations:

☐ Inspira Medical Center
Elmer
501 West Front Street
Elmer, NJ 08318
856-363-1000

☐ Inspira Medical Center
Vineland
1505 West Sherman Avenue
Vineland, NJ 08360
856-641-8000

☐ Inspira Medical Center
Woodbury
509 North Broad Street
Woodbury, NJ 08096
856-845-0100

☐ Inspira Health Center
Bridgeton
333 Irving Avenue
Bridgeton, NJ 08302
856-575-4500

My Confidential Information:

By signing my name next to a category of highly confidential information listed below, I **do not permit** the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- HIV/AIDS Related Information_____
  (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative.)
- **Mental Health Information*_____**
  (including Psychotherapy Notes)
- **Drug and Alcohol Information*_____**

***This information has been disclosed to you from records whose confidentiality is protected by Federal law (42CFR Part 2) which prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains or as otherwise permitted by such regulation.**

RECIPIENT (Name of person to whom Inspira Health Network may disclose my health information):			
Name:	**Phone#**	**Fax#**	
Address	**City**	**State**	**Zip**
City	**State**	**Zip**	

TERM: This Authorization will remain in effect for 180 days from the signature date unless specified below:

❑ From the date of this Authorization until:_____

❑ Other: _____

PURPOSE OF AUTHORIZATION:

☐ Personal Use by Patient ☐ Send to other Health Care Provider ☐ Insurance Coverage ☐ Caregiver instruction ☐ Other (please specify):

AUTHORIZATION:

- I hereby authorize Inspira Health Network to disclose the health information described above.
- I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.
- I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing to: Inspira Health Network's Privacy Office at Inspira Health Network, 2950 College Drive Suite 1E, Vineland, NJ or by email privacyoffice@ihn.org.
- I understand that any revocation will be effective immediately upon its receipt of my written notice, except that the revocation will not have any effect on any action taken by Inspira Health Network in reliance on this Authorization before it received my written notice of revocation.
- I understand that once Inspira Health Network discloses my health information to the recipient, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that I may refuse to sign (at any time) this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Inspira Health Network; except, however, if my treatment at Inspira Health Network is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Inspira Health Network may refuse to treat me if I do not sign this Authorization.

I have read and understand the terms of this Authorization. By my signature below, I hereby, knowingly and voluntarily, authorize Inspira Health Network to use or disclose my health information in the manner described above:

Signature of Patient:_____ **Date:**_____ **Time**_____
If the patient is a minor or is otherwise unable to sign this authorization, obtain the following signatures:

Signature of Personal Representative:_____

Description of Authority:_____ **Date:**_____ **Time**_____

For Hospital Use Only: A copy of this Authorization shall be placed in the patient's medical record. Inspira Health Network must provide a copy of the signed Authorization form to the patient or representative.
Hospital Representative:_____ **Date:**_____ **Time**_____