Christian Health Care Center
301 Sicomac Avenue
Wyckoff, New Jersey 07481
(201) 848-5200 • www.chccnj.org

AUTHORIZATION FOR RELEASE OF INFORMATION FROM CHCC

Patient name_____ **Date of birth**_____

I_____ do hereby consent to and authorize
(Patient/Legal Representative)
(Please circle program) (Ramapo Ridge Psychiatric Hospital, Ramapo Ridge Partial Program, Christian Health Care Counseling Center, Heritage Manor Nursing Home, The Longview Assisted Living Residence, Southgate, Hillcrest, Adult Day Services Wayne/ Wyckoff)
to disclose my patient's medical records, including Protected Health Information (PHI) to:

_____
Name of person or health-care facility receiving information *Telephone:*

*Address:*_____

Specific dates of information to be released:_____

This request is for the purpose of: (please circle) Continuing Care, Financial, Legal, Personal use. The patient/legal representative understands that the PHI released may specify: Mental health and Psychotherapy Information, including but not limited to information on medications, side effects and special precautions, Drug and Alcohol Information, HIV/AIDS Related Information, Sexually Transmitted Disease Information and Tuberculosis information. If the patient/legal representative does not wish to release specific information, please specify: _____

Information to be disclosed: (i.e. discharge summary, history and physical, etc.)

_____

CONDITIONS
The patient/legal representative agrees to authorize the above named individual(s)/organization to access his/her confidential healthcare information only for the purposes listed above. The patient/legal representative understands that the information specified above may be re-disclosed and no longer protected by the federal privacy laws, if the individual(s)/organization is not a health care provider or health plan covered by federal privacy regulations. The patient/legal representative is voluntarily signing this authorization. The patient/legal representative reserves the right to revoke this authorization at any time by notifying the Privacy Officer in writing. The patient also understands that if the authorization is revoked, it won't have any affect on any actions taken prior to receiving the revocation. This authorization is in effect for twelve (12) months. The patient/legal representative may request a copy of the signed authorization. This authorization will be maintained by CHCC per applicable State and Federal laws.

SIGNATURES

_____ _____
Patient/legal representative Date Time

_____ _____
Printed Name of Legal Representative (if applicable) Relationship to Patient

_____ _____
CHCC Representative/Witness Date Time

NOTICE TO RECIPIENT OF INFORMATION

If the patient/legal representative authorized release of Alcohol and Drug abuse information, as indicated on this form, the following Notice applies to the information you have received pursuant to this authorization: This information has been disclosed to you from Records protected by federal confidentiality rules 42CFR Part 2. Federal rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent from the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Internal Use Only:
Date/Time Information Sent:_____Information Sent:_____
Signature of Sender:_____To be sent Post-discharge:_____