Authorization to Disclose Protected Health Information

I hereby authorize:

- ❑ Atlanticare Regional Medical Center (609-449-4308)
- ❑ Shore Medical Center (609-926-4344)
- ❑ Cooper University Health Care (856-342-2687)
- ❑ Other:

to send protected health records to my Primary Care Provider for continuity of care. My PCP is located at:

Unite Here Health Center
1801 Atlantic Avenue, 3 Fl., Atlantic City NJ 08401

Fax: (609) 441-7207 Attention: MHSP
Phone (609) 570-2400

Please include the following related to these dates _____-_____,_____:

- ❑ Hospitalization Discharge Summary (or Last Note)
- ❑ Emergency Department Provider Note
- ❑ Most Recent Outpatient Clinic Visit Note
- ❑ Surgical Operative Notes
- ❑ Behavioral Health Record
- ❑ Alcohol & Substance Dependence
- ❑ Sexually Transmitted Infections (including HIV)
- ❑ Medication & Medical History
- ❑ Lab Test Results related to visit
- ❑ Radiology (including Ultrasound, CT or MRI)
- ❑ Cardiac Tests (Echo, Stress Test, Cath, Device)
- ❑ Procedure Notes & related Pathology Reports
- ❑ Other:

By signing the below, I have understood:

- I do not have to sign this authorization to receive care or treatment from my PCP.
- My health information is considered protected under Health Insurance Portability and Accountability Act (HIPAA) and other applicable state and federal regulations.
- My protected health information (PHI) will be part of my patient records with my PCP.
- I have the right to revoke this authorization with my PCP by calling them, or by sending a written letter to the sending organization (AtlantiCare, Shore, Cooper, etc).
- I am entitled to a copy of the signed version of this form.
- This authorization is valid from the date I sign below to 12/31/2018_____*(date or event)*.

_____

Patient's Full Name Date of Birth Home Address

_____

Patient or Legal Guardian Signature Phone Number Date Signed

_____

For minors or patients unable to sign, please include the full name of the Legal Guardian