Bacharach
INSTITUTE FOR REHABILITATION

Health Information Management Services

Phone: 609-748-5391
Fax: 609-748-6869

Hours of Operation: 8:30 AM to 4:30 PM

Request for Personal Health Information

To request a copy of your medical records, please complete an Authorization for Release of Information Form which can be downloaded from our website or picked up at any of our therapy centers. Please complete each section and specify the date and type of service. The form must be signed and dated by the patient or legally authorized representative to be valid. Instead of the form, a handwritten request specifying the information requested is also acceptable. You can fax the completed form to 609-748-6869 or mail it to the address below. In-person requests can also be made at the Health Information Management Department at the following address:

Bacharach Institute for Rehabilitation
61 W. Jimmie Leeds Road
P.O. Box 723
Pomona, NJ 08240
ATTN: Health Information Management Services

Original records remain the property of the hospital. There may be a fee charged for copies of medical records. Requests are usually processed within 7 days.

REQUESTS FROM HEALTH PROVIDERS for PATIENT INFORMATION

An authorization indicating the specific information needed may be faxed to Health Information Management Services at 609-748-6869. If the patient is currently in the office, please advise us by calling our Release of Information Clerk at 609-748-5391.

CONTACT INFORMATION

If you have any other questions or need further assistance, please contact us at 609-748-5391.

Bacharach
INSTITUTE FOR REHABILITATION
61 W. Jimmie Leeds Road, Pomona, NJ 08240 (609) 652-7000

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

ALL CHECKED AREAS MUST BE COMPLETED FOR AUTHORIZATION TO BE VALID.

X Patient Name:_____ **X Date of Birth:**_____

X Patient Address: _____ **Phone:**_____

I hereby authorize Bacharach Institute for Rehabilitation to release my health information described below to:

X Recipient Name: _____ **Phone:**_____

X Recipient Address: _____

X Type of Service: ☐ Inpatient _____ ☐ Outpatient _____
(Date of Service) **(Date of Service)**

X Documents/Information to be Released:

☐ Discharge Summary
☐ History & Physical Exam
☐ Consultation Report from (doctors' names/date) _____
☐ Laboratory results: _____
☐ X-ray and imaging reports: _____
☐ Physical Therapy
☐ Occupational Therapy
☐ Other Therapy (specify) _____
☐ Other: _____ _____

X For the Purpose of: _____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and alcohol and drug abuse. I am aware there is a statutory privilege accorded by NJSA 45:14B-28 to confidential communications between a patient and a licensed psychologist.

I understand I have the right to revoke this authorization in writing at any time. I understand the revocation will not apply to information that has already been released in reliance on this authorization. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send or present it to:

Bacharach Institute for Rehabilitation, Inc.
61 West Jimmie Leeds Road
Pomona, New Jersey 08240-0723
Attention: Health Information Management Services

I understand that authorizing the disclosure of this information is voluntary, and I can refuse to sign this authorization. The hospital may not condition treatment on my signing this form. I understand that the information used or disclosed pursuant to this Authorization may be subject to unauthorized re-disclosure by the recipient listed above and, in that case, will no longer be protected by federal privacy rules. Unless otherwise revoked, this authorization expires upon Bacharach's release of the information described above or _____ days after the Date of Authorization, as set forth below, or on the following date, event or condition: _____, whichever comes first. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

X _____ **X** _____
Signature of Patient or Legal Representative **Date**

_____
If Signed by Legal Representative, Relationship to Patient

X To be completed in the event Bacharach is seeking the authorization:
I hereby acknowledge receipt of a copy of this Authorization. _____ _____
Signature of Patient or Legal Representative Date

Information Requested Sent by: _____ Dept: _____ _____ Date: _____