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

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

Patient Address: _____

I hereby authorize _____
to release my health information described below to:

Recipient Name: _____

Recipient Address: _____

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

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: _____
_____

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.

_____ _____
Signature of Patient or Legal Representative **Date/Time**

_Printed Name----------

_____
If Signed by Legal Representative, Relationship to Patient

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/Time

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