



Center for Comprehensive Breast Care  
 2 Capital Way  
 Suite 505  
 Pennington, NJ 08534

## Authorization for Patient Access/Release of Health Information

Patient Name:				Medical Record #:					
Date of Birth:			Phone #:						
Home Address:				City:		State:		Zip:	
<b>1. Type of Request:</b> I hereby request the following:									
<input type="checkbox"/> Access to review my original medical record				<input type="checkbox"/> Release/Disclosure of my health information, as requested below					
<input type="checkbox"/> Request my medical records from another facility				Name of Facility:					
<b>2. Description of Information To Be Released:</b> <i>(Check ALL that apply)</i>									
<input type="checkbox"/> Abstract* (defined below)		<input type="checkbox"/> Entire Medical Record			<input type="checkbox"/> History and Physical			<input type="checkbox"/> Operative Reports	
<input type="checkbox"/> Immunization Record		<input type="checkbox"/> ER Record			<input type="checkbox"/> Progress Notes			<input type="checkbox"/> X-ray Reports	
<input type="checkbox"/> Outpatient Records		<input type="checkbox"/> Consultation Reports			<input type="checkbox"/> EKG/EEG			<input type="checkbox"/> Discharge Summary	
<input type="checkbox"/> Treatment Record		<input type="checkbox"/> Labs			<input type="checkbox"/> Other (specify):				
Date of Service									
(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)									
I understand that the specific information to be released may include reference to alcohol abuse, drug abuse, AIDS/HIV infection, sexually transmitted diseases, tuberculosis, and/or psychiatric conditions and the treatment of any of these disorders. If this information is documented in my medical record, I agree to the release of it.									
<b>3. Disclose/Send Information To:</b>									
<input type="checkbox"/> Myself <i>(the patient or authorized representative)</i>				<input type="checkbox"/> To Organization/Individual below:					
Organization:				Individual Name:			Phone #:		
Street Address:		City:		State:		Zip Code:			
								<input type="checkbox"/> Please Mail	
								<input type="checkbox"/> Please prepare for pick-up	
<b>4. Purpose of Release:</b> I authorize Capital Health to release my health information for the following specific purpose:									
<b>5. Term/Expiration:</b>									
I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by providing a written revocation to Capital Health, Health Information Management Department at either campus. This authorization will automatically expire twelve (12) months from the date listed below. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.									
<b>6. Fees:</b>									
Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care.									
Signature of Patient or Patient's Representative					Date				
Relationship to Patient					Witness Signature				