HACKENSACK MERIDIAN HEALTH
30 Prospect Avenue, Hackensack, New Jersey 07601
Phone: (551)996-2254 Fax: (551) 996-3977

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Radiology Department - Phone 551-996-2254

I hearby authorize use or disclosure of the named individul's health information as described below.

Patient Name	Date of Birth	Social security number
Address (Street,City, State, Zip Code)		Telephone Number
The following organization is authorized to make the disclosure		
Hackensack Meridian Health		
Treatment dates:	Purpose of Request:	
The following information is to be disclosed:		

Yes	No	
		Radiology or Imaging Reports

Sensitive information: I understand that the information in my record may include information related to sexually transmitted diseases, acquired immunodeficency syndromed (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug and drug abuse.

Right to Revoke: I understand that I have the right to revoke the authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: if I do not specify an expiration date event or condition, this authorization will expired in six months.

Redisclosure: I understand that any disclossure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study. I may be denied enrollment in the research study. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164-524.

Signature of Patient or Legal Representative	Date:
If signed by legal representative: Relationship to Patient	