SHORE PHYSICIANS GROUP℠

PATIENT ID/LABEL HERE:

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION
(USED TO SEND SPG RECORDS TO THE PATIENT OR THEIR DESIGNEE)

PLEASE PROVIDE THE PATIENT WITH A PHOTOCOPY OF THIS COMPLETED FORM

Patient Information:

Patient Name: _____

Maiden Name/Alias: _____

Date of Birth: _____ Social Security Number: _____

By signing this authorization form, I authorize Shore Physicians Group (SPG) to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below to the following person or organization:

Name of person/organization: _____

Street address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____ Facsimile number: _____

Purpose of use/disclosure: _____

I specifically authorize the use/disclosure of the following PHI: (***Please provide a detailed description of the particular dates and timeframes of your treatment)***

☐ Emergency Records _____
☐ Hospital Records/Inpatient Records: _____

☐ Face sheet ☐ History and Physical ☐ Social Service/DC Planning Notes
☐ Discharge Summary ☐ Operative Report(s) ☐ Drug/Medication Records
☐ Consent to transfer ☐ Progress Notes
☐ Other: _____

☐ Clinic/Outpatient Records:_____
☐ Laboratory Report(s): _____
☐ Pathology Report(s): _____
☐ Radiology Report(s): _____ ☐ Radiology Images: _____
☐ Consultation Report(s): _____
☐ EKG/Cardiac Report(s): _____
☐ Other: _____

SHORE PHYSICIANS GROUP℠

PATIENT ID/LABEL HERE:

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

(USED TO SEND SPG RECORDS TO THE PATIENT OR THEIR DESIGNEE)

I understand that once SPG discloses my PHI to the recipient, SPG cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by the Authorization or applicable federal and state law governing the use and disclosure of my health information.

I may revoke this authorization at any time by notifying my SPG office in writing to the following address: **Shore Physicians Group, 100 Medical Center Way, 4th floor Administrative offices, Somers Point, NJ 08244**

However, I also understand that such a revocation will not have any effect on any information already used or disclosed by SPG prior to SPG receiving my written notice of revocation. In addition such refusal or revocation will not affect the commencement, continuation or quality of my treatment at SPG.

If you believe your privacy rights have been violated, or you disagree with a decision we made about access to your protected health information, you may contact the Privacy Office by calling 1-866-314-4722 or 1-609-926-4300 or at the above listed address to the attention of the Privacy Office.

Term of Authorization: This authorization will remain in effect for 90 days unless otherwise specified below: (*Initial the applicable box)*

_____ From the date of this authorization until the _____ day of _____, 202__
_____ Until the following event occurs: _____

INFORMATION OF THE BELOW NATURE WILL BE RELEASED UNLESS YOU SPECIFICALLY INITIAL ITEMS NOT TO BE RELEASED. I understand that my medical record may contain information related to some of the following

_____ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
_____ Psychiatric information
_____ Treatment for Alcohol and/or drug abuse
_____ Venereal disease information
_____ Tuberculosis information
_____ Genetic information

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize SPG to use or disclose my PHI in the manner described above.

_____ _____
Signature of Patient — Date Signed

_____ _____
Signature of Personal Representative — Date Signed

_____ _____
Print Name of Assisting SPG Staff Member — Date

FOR SPG USE WHEN INFORMATION IS RELEASED: **EXCEPTIONS REQUESTED?** ☐ **YES** ☐ **NO**

Date released: _____/_____/_____ Signature of SPG Staff Member: _____

Total pages: _____ Total Charge: _____

PROVIDED THE PATIENT A PHOTOCOPY OF THIS COMPLETED FORM? ☐ **YES** ☐ **NO, PATIENT DECLINED**