AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE (HIPAA COMPLIANT)

TO: OCEAN COUNTY ADJUSTER

PATIENT INFORMATION

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
MM/DD/YYYY

I hereby authorize the designated records custodian of the HIPAA covered individual or entity identified above to disclose all of my protected health information. I expressly request that you disclose, make available and furnish to the individuals/entities listed below:

_____, PATIENT

_____,

Full and complete copies of all records and reports in the custody of the Ocean County Adjusters Office regarding my medical condition and or treatment including but not limited to:

a) All information, records, x-rays, reports or copies thereof relating to my examination, consultation, confinement or treatment. You are also authorized to provide psychiatric, drug and/or alcoholic information.

b) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

c) I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Ocean County Adjuster. I understand the revocation will not apply to information that has already been released in response to this authorization.

AUTHORIZATION FOR HEALTH
INFORMATION DISCLOSURE
(HIPAA COMPLIANT)

d) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R.164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: The Ocean County Adjuster.

Patient or Legal Representative and Relationship: _____ Relate: _____
Signature

_____ Date: _____
Print Name

Witness _____ Relate: _____
Signature

_____ Date: _____
Print Name

State of New Jersey, County of _____, ss

I CERTIFY that on _____, _____, _____, and
Day Month Year

_____, personally came before me and acknowledged under oath and to my satisfaction, that this person is named in and personally signed this document.

Signed _____

Print Name _____, Notary Public

My commission Expires: _____, _____