RM-0211-1216

State of New Jersey • Department of the Treasury
Division of Pensions and Benefits • PO Box 295 • Trenton, NJ 08625-0295 • (609) 292-7524

AUTHORIZATION TO DISCLOSE HOSPITAL RECORDS

Patient Name _____ Date of Birth _____

Address _____

Telephone _____

IF THERE IS ANY CHARGE FOR THIS SERVICE, THE PATIENT WILL REIMBURSE THE REPORTING ENTITY.
DO NOT SEND BILLS FOR SERVICE TO THE DIVISION OF PENSIONS AND BENEFITS.

I hereby authorize the following entity _____
Name of Hospital / Workers' Compensation Center / Employer
to release my health information to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295.

Indicate records source:
☐ Hospital
☐ Workers' Compensation Center
☐ Employer's Doctor's Evaluations
☐ Employer's Doctor's Evaluations

The information to be disclosed to and used by the above is for the purpose of determining eligibility for disability retirement. **The Division of Pensions and Benefits may also disclose this information to my employer for the purpose of determining eligibility for disability retirement.**

This authorization is limited to the following dates of treatment:

From _____ To _____

A *Discharge Summary* must be included along with the following as indicated:

☐ EMERGENCY ROOM RECORD
☐ CONSULTATIONS
☐ COMPLETE RECORD
☐ HISTORY & PHYSICAL EXAM
☐ PROGRESS NOTES
☐ EEG TRACINGS
☐ OPERATIVE REPORTS & PATHOLOGY
☐ LAB, X-RAYS & TESTS
☐ PATHOLOGY SLIDES
☐ OTHER _____

I understand that the information to be disclosed includes my identity, diagnosis, and treatment, including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED AND INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

It is my intent that the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that 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 entity named above. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization. If there is any charge for this service, I will reimburse the reporting entity. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date _____.

Patient Signature _____ Date _____