# Authorization to Disclose Health Information

| Clients Name | DOB | Phone | |
|---|---|---|---|
| Street Address | City | State | Zip |

I hereby authorize the Medical Records Staff of:____________________________________________
to disclose my health information to:

**1st CEREBRAL PALSY OF NEW JERSEY**
REQUESTOR'S NAME
**7 SANFORD AVENUE**
REQUESTOR'S ADDRESS
**BELLEVILLE. NEW JERSEY 07109-1221**
CITY STATE ZIP CODE

The information to be disclosed to and used by the above is for the following purpose:____________________

______________________________________________________________________

______________________________________________________________________

This authorization is limited to the following dates o f treatment: FROM:__________________TO:__________________
Information to be disclosed:

- ❑ **EMERGENCY ROOM RECORD**
- ❑ **HISTORY & PHYSICAL EXAM**
- ❑ **OPERATIVE KEPT / X-RAYS REPORTS**
- ❑ **DISCHARGE SUMMARY**
- ❑ **CONSULTATIONS**
- ❑ **PROGRESS NOTES**
- ❑ **NURSES' NOTES**
- ❑ **BEHAVIORAL/DEVELOP. NOTES**
- ❑ **NEUROLOGICAL NOTES**
- ❑ **BIRTH RECORDS**

**I understand that the information to be disclosed includes my identity, diagnosis and treatment.**

It is my intent that the use of 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 1st Cerebral Palsy Center. I understand that this revocation will not apply to the extent that ____________________________has already taken action in reliance on this authorization. This authorization will automatically expire: ___________________, 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, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the ***Medical Records Department at***
____________________________________.

| Signed (Parents/Guardians/Foster Parents) | Date |
|---|---|
| Printed Name of (Parents/Guardians/Foster Parents) | Relationship |