VISITING NURSE ASSOCIATION HEALTH GROUP, INC.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ AKA: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

I hereby authorize Visiting Nurse Association Health Group (VNAHG) and its affiliates to use and/or disclose my health information as described below. I understand that authorizing the disclosure of this information is voluntary and I do not have to sign this form in order to receive treatment from VNAHG. I also understand that information that is used and/or disclosed pursuant to this authorization may not be protected from re-disclosure by the recipient unless the recipient is covered by New Jersey law or other laws that prohibit the re-disclosure of such information. I understand that I will be given a copy of this form after I sign it.

1. Description of Information to be used/disclosed (include dates of service):

_____

_____

NOTE: I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

____ Treatment for alcohol abuse ____ Treatment for substance abuse ____ Genetic testing results

____ Sexually transmitted disease(s) ____ Tuberculosis and other diagnosis ____ AIDS/HIV information

____ Behavioral or Mental Health disorder(s) ____ Psychotherapy notes treatment of Mental Health/Behavioral condition

2. Person(s)/entity authorized to receive requested information:

3. Description of each purpose of the requested use/disclosure:

At the request of patient (when patient initiates request).

Other individual (please specify): _____

_____

☐ If disclosure is for marketing purposes and VNAHG receives compensation from a third party, VNAHG shall indicate here.

4. Expiration of Authorization: I understand that I have the right to revoke this authorization at any time by submitting a written revocation to the following address: The Privacy Official, 23 Main Street, Suite D1, Holmdel NJ 07733. I understand, however, that such revocation will not apply to actions VNAHG takes in reliance on the authorization before the revocation of authorization is received. Unless otherwise revoked, this authorization will expire on the following date (MM/DD/YEAR) or upon the following event: _____. If no date or event is specified, this authorization will expire in one year from the date signed.

_____ _____

Signature of Patient or Authorized Representative* Date

_____

Print Name

_____ _____

Signature of Witness Date

_____

Print Name

_____

*If signed by Authorized Representative, print Authorized Representative's name and describe legal authority to act on patient's behalf.

Send completed, signed authorization form to: Medical Records, 3600 Route 66, Neptune, NJ 07753
Telephone (800) 862-3330 Fax (732) 784-9708

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65.