



CENTRAL JERSEY INTERNAL
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
(patient name) (name of facility which has information)
 Release the following health information _____
TO _____

(address) (telephone) (fax)
 For the following purposes: _____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signature of Patient: x _____	Date: ____/____/____
Or Signed by Personal Representative: x _____	Date: ____/____/____
On Behalf of: x _____ <small>(patient name)</small>	