REQUEST FOR MEDICAL RECORDS

Acuity Specialty Hospital of Southern New Jersey

Patient Request for Release of Information_____

I AM A PATIENT OF ACUITY HEALTHCARE OR THEIR REPRESENTATIVE AND THE PATIENT INFORMATION IS LISTED BELOW (PLEASE PRINT):

First Name:	MI:	Last Name:
Date of Birth:	Phone:	Last 4 digits SSN:
Address:	City:	State & Zip:

WHICH RECORDS WOULD YOU LIKE TO RECEIVE? (ENTER THE ADMISSION AND DISCHARGE DATE, THEN SELECT THE APPROPRIATE BOX(ES)):

Admission Date: Discharge Date:

☐ Discharge Summary	☐ Diagnostic Test Results	☐ Drug/Alcohol Records	☐ Face Sheet
☐ History & Physical	☐ Laboratory Results	☐ HIV Records	☐ Abstract
☐ Consultations	☐ X-ray/CT/MRI Reports	☐ Mental Health Records	☐ Itemized Bill
☐ Progress Notes	☐ Pathology Reports	☐ Medications	
☐ Operative Reports	☐ EKG's / ECG's	☐ Other (Please Specify): _____	

HOW WOULD YOU LIKE TO RECEIVE THE REQUESTED MEDICAL RECORDS?

Select one: ☐ CD ☐ Fax ☐ E-mail ☐ Paper Copies → ☐ Mail ☐ On-site Pick Up ☐ Review Medical Record on-site/in person

NOTE: E-mail and CD will be encrypted or password protected unless otherwise requested here → ☐ No encryption or password required

WHEN WOULD YOU LIKE TO RECEIVE THE REQUESTED MEDICAL RECORDS? _____

NOTE: We will make every effort to send your records as soon as possible but this process may take up to 30 days.

PLEASE INDICATE WHERE YOU WOULD LIKE THE RECORDS TO BE SENT (PLEASE COMPLETE APPLICABLE SECTION(S) BELOW):

Acuity Healthcare should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail:

THIS AUTHORIZATION WILL EXPIRE IN 6 (SIX) MONTHS OR (SPECIFY DATE OR EVENT): _____

Printed Name of Patient or Personal Representative:	Relationship (please print):
Signature of Patient or Personal Representative:	Date: Time:

PLEASE RETURN COMPLETED AND SIGNED FORM TO:

Health Information Management Director - ROI Acuity Specialty Hospital of Southern New Jersey 220 Sunset Road, Suite 1B Willingboro, NJ 08046	Fax: 609-526-7746 Phone: 609-835-3657

- Acuity Healthcare recognizes a patient's right under HIPAA to access copies of his/her health information.
- There may be a fee associated with producing requested records. Please see the fee schedule for this Acuity Healthcare facility.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

For Office Use Only

Date of release: _____via mail fax CD other_____ ID verified DL/Other ID_____

Employee Name & Title: _____Date: _____ Time: _____

***** ATTENTION *****