RUTGERS
New Jersey Medical School
Occupational Medicine Service

Authorization To Release Medical Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

1. I hereby request and authorize the Rutgers New Jersey Medical School Occupational Medicine Service to release information from the occupational medical record(s) of:

__________________________ ____________ ____________________
Patient's Name Patient's Date Of Birth Patient's Telephone Number

__________________________ __________________________
Patient's Title Patient's Department

I understand that this authorization includes permission to release information related to the history, diagnosis, and / or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted disease, AIDS, or infection with human immunodeficiency virus (HIV).

2. **PLEASE NOTE: Documentation requests take 1 to 7 business days to process.** Select **ONE** option. The records should be sent:

☐ For Pick Up By Me ☐ By E-Mail Recipient's Name / E-Mail: ____________________

☐ By Fax Recipient's Name / Fax Number: ____________________

☐ By Mail Recipient's Name: ____________________

Recipient's Address: ____________________

____

3. The information to be released is and the records to be sent include (please provide dates of treatment and specific records):

__________ Immunizations
__________ TB Skin Tests / Chest X-Ray Reports
__________ Physical Examinations
__________ Copy Of My Medical Record
__________ Viral Titers
__________ TB Evaluation / Treatment
__________ Lab Tests
__________ Job-Related Incident / Exposure

Other____________________________________

4. Purpose / reason for release of records: ○ Personal ○ Work ○ School ○ Legal Matters ○ Other: ____________________

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

6. I understand that my treatment is not conditioned on obtaining this authorization.

7. I understand that this authorization is specific for release only to the above party and expires ninety (90) days following the date of signature.

8. I understand that the information used and disclosed may no longer be protected by the federal privacy laws.

9. I understand that I may be charged for copies of my records according to the fee established in the New Jersey Administrative Code.
- The first copy is free of charge to employees. Additional copies are $1 per page, with a $10 minimum and a $100 maximum.
- **ONLY** acceptable forms of payment are personal check or money order made out to Rutgers Occupational Medicine Service.

10. If requested information involves my mental health, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed health care provider and release of such information may waive this privilege.

11. I understand that if this authorization is for marketing purposes, then Rutgers University may receive direct or indirect compensation.

__________________________ __________________________
Printed Name of Patient Printed Name of Patient's Representative

__________________________ __________________________
Signature of Patient Signature of Patient's Representative

__________________________ __________________________
Date Relationship to Patient

65 Bergen Street, Suite GA-167
Newark, NJ 07107
njms_occmed@njms.rutgers.edu
Phone: 973.972.2900
Fax: 973.972.2904