

**SAINT BARNABAS  
HEALTH CARE SYSTEM**  
*Saint Barnabas Outpatient Centers*  
200 South Orange Avenue, Livingston, NJ 07039

For Office Use Only:  
M.R.#  
P.A.#

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

PATIENT NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

I hereby authorize the Pediatric Specialty Center staff of Saint Barnabas Medical Center of Livingston, NJ to disclose my health information to:

**PEDIATRICIAN:** \_\_\_\_\_

**ADDRESS AND FAX NUMBER (MUST HAVE):** \_\_\_\_\_

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

**RESULTS OF CARDIAC SCREENING**

This authorization is limited to the following dates of treatment:

FROM \_\_\_11/15/08\_\_\_\_\_ TO \_\_\_11/15/08\_\_\_\_\_

**Information to be disclosed:**

**Results of Cardiac Screening**

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. **FOR ONGOING TREATMENT THIS AUTHORIZATION WILL NOT EXPIRE.**

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 Department Director. I understand that this revocation will not apply to the extent that Saint Barnabas Outpatient Center has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: \_\_\_\_\_.

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, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_