RUTGERS–NEW BRUNSWICK
Student Health
Division of Student Affairs

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|---|---|---|
| **Medical** | Telephone: 848-932-7402 | Fax: 732-932-8255 |
| **Counseling** | Telephone: 848-932-7884 | Fax: 732-932-8278 |
| **ADAPS** | Telephone: 848-932-7884 | Fax: 732-932-8278 |
| **Psychiatry** | Telephone: 848-932-7884 | Fax: 732-932-8278 |


# *AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION*

1. I hereby give permission to:
   - □ Counseling, Alcohol and Other Drug Assistance Programs, and Psychiatric Services (CAPS)
   - □ Medical Services

2. To disclose the health information of:

   Patient/Client _____ (First MI Last)
   Date of Birth _____
   RUID # _____
   Other ID _____
   Address _____
   City/State _____
   _____
   Zip Code _____
   Patient/Client Email _____
   Patient/Client Mobile Phone _____

3. Release, obtain, or discuss health information:
   - □ Release information to
   - □ Obtain information from
   - □ Discuss information on an ongoing basis with _____

4. Person or organization that information/records are to be released to or obtained from, including Name, Address, Phone, and Fax (if applicable):

   Name _____
   Zip Code _____
   Address _____
   Telephone (Home) _____
   _____
   Telephone (Cell) _____
   City/State _____
   Fax _____

5. Purpose of disclosure:
   - □ Further health care
   - □ Legal investigation
   - □ Personal use
   - □ Other _____
   - □ Verification of attendance
   - □ Payment of insurance claim
   - □ Academic accommodations
   - □ Further mental health evaluation/treatment
   - □ Planning and/or coordination of ongoing care

6. Type of Service/Record (Medical)
   Health Centers:
   - □ Hurtado Health Center
     11 Bishop Place, New Brunswick, NJ 08901
     Telephone: 848-932-7402
     Fax: 732-932-8255
   - Busch-Livingston Health Center
     110 Hospital Rd.Piscataway, NJ 08854
     Phone-848-445-3250
     Fax:732-445-3724
   - Willets Health Center
     11 Suydam St. New Brunswick, NJ 08901
     Phone: 732-932-9805
     Fax: 732-932-1465

7. **MEDICAL INFORMATION TO BE RELEASED**

   **Please check the appropriate sections of the health record to be released (check all that apply):**

   - □ Records only related to the following date(s) of service _____
   - □ Medical Clinic Note(s)
   - □ Pathology Reports
   - □ Lab Reports
   - □ Consultant Reports
   - □ Most Recent Gynecological Exam/Pap smear
   - □ Social Service/Government Employment Information
   - □ Radiology Reports
   - □ Billing Records
   - □ Immunizations
   - □ Pharmacy Records
   - □ Sexual Assault information
   - □ Record of attendance at appointments for the following dates:
     FROM: _____ (Month Day Year)
     TO: _____ (Month Day Year)
   - □ Other _____
   - □ Records which may indicate the results of genetic testing or discussion _____(initial)
   - □ Records which may indicate the presence of a sexually transmitted infection which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS treatment, testing, or discussion_____(initial for release).

   ***Please note that an authorization for the release of **all Medical Clinic Notes** may disclose sensitive information about your **mental health, drug or alcohol use, episodes of domestic violence or sexual assault, and history or treatment for Sexually Transmitted Infections.**

8. Type of Service/Record (CAPS)
   CAPS Facility/Unit:
   - □ Counseling & Psychological Services
   - □ Psychiatric Services, Counseling Center

17 Senior St.
New Brunswick, NJ 08901
(848) 932-7884

17 Senior St.
New Brunswick, NJ 08901
(848) 932-7884

□ ADAP (Alcohol Drug Assistance Program for Students)
CAPS Center
17 Senior St.
New Brunswick, NJ 08901
(848) 932-7884

□ 185 Bevier Road
Piscataway, NJ 08854
(848)-932-7884

9. **CAPS INFORMATION TO BE DISCLOSED**

**Please check the appropriate sections of the health record to be released (check all that apply):**

□ Attendance Confirmation on the Following Date(s): _____

□ Intake Assessment – Written Summary Psychiatric

□ Psychiatric Evaluation/Treatment/Treatment Planning – Written Summary

□ Psychological Counseling Evaluation/Therapy – Written Summary

□ Alcohol/Drug Information – Written Summary

□ Other: _____

□ Verbal Summary Information

□ Evaluation/Treatment/Treatment Planning – Written Summary

□ Termination Summary

□ Sexual Assault Information

10. How would you like the disclosure to occur?

□ Fax Document
□ Mail Document
□ Other _____

11. Special Instructions about Information Released:

_____

_____

_____

_____

12. This disclosure will expire one year from "Today's Date" listed below.

I understand that my medical records are protected under N.J. regulations applicable to physicians and other health care professionals. I also understand that my records are protected under the Federal Protected Health Information regulations. I have the right to review my medical records except in specific limited circumstances, and to request amendments where appropriate. My health information may be subject to re-disclosure and not protected by Federal or State Statutes in the occurrence of a medical emergency, reporting of communicable disease as required under NJ Public Health statutes, disclosure in response to a subpoenas duce tenem or court order, or required disclosure to a government agency. Specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals, and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions. There may be a fee as permitted under NJAC for copying medical records. I understand that I may revoke this authorization at any time by notifying Rutgers Health Services (RHS) in writing, except that revocation will not cancel any action taken by RHS upon the original Authorization for Release of PHI.

I understand that this information, regarding the ADAPS treatment record, has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation [42 CFR, Part 2] prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.

**►Patient Signature** _____ **Today's Date**_____
**(Signature Required)**

**FOR OFFICE USE ONLY**

Records Release Completion

□ **Prior to release, secure fax confirmed**
□ Records copied and mailed as requested
□ Records copied and faxed as requested
□ Records copied and given as requested to person(s) indicated above
□ Other _____