New Jersey

Authorization for Release Of Protected Health Information
Medical Authorization

Patient's Name	Date of Birth	Social Security Number (optional)

I authorize New Jersey Medicaid (the "Keeper of the Records") to disclose my protected health information as specified below. I understand that signing this Authorization is voluntary and that my treatment may not be conditioned on the signing of this authorization. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to the Keeper of the Records. I understand that I cannot revoke this Authorization to the extent this Authorization has been relied upon. I understand that information released pursuant to this Authorization may no longer be protected by law or regulation and may be redisclosed by the recipient.

1) (a) Please disclose the entire medical record including any and all medical information and opinions (whether written or oral), office notes pertaining to my physical or mental condition and physical or medical treatment rendered therefore, and allow Lien Resolution Group or their representative to see and obtain copies of all records, notes, reports, X-rays, medical tests, studies, and correspondence, including correspondence to and from other medical providers and insurance companies regarding my condition and /or treatment.

   (b) The Keeper of the Records cannot use or disclose certain information unless the patient specifically authorizes such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis, or treatment for:

   _____ HIV/AIDS
   _____ Drug and alcohol abuse
   _____ Mental health/psychiatric disorders

2) All information maintained at any time by the Keeper of the Records may be disclosed.
3) The information requested by this Authorization may be received by _____.
4) The information is being requested for the purposes of discovery during litigation between _____.
5) Unless revoked earlier, this authorization will expire at the resolution of the litigation, whether by settlement, verdict or judgment, inclusive of the period of time for any appeal.

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization
- I have been given a copy of this Authorization
- I am authorizing the Keeper of the Records to use or disclose my health information to the persons and for the purposes identified in this Authorization; and
- If I have any questions about the disclosure of my protected health information pursuant to this Authorization, I may contact the Keeper of the Records.
- **A photocopy of this authorization shall be considered as effective and valid as the original.**

Print Name	Signature of Patient or Personal Representative	Date

If signed by the patient's personal representative, describe the legal authority of the representative to act on behalf of the patient_____.

Legal authority of representative verified by _____.