

- Release is to be limited to the specified report(s) within the specified date(s) of treatment indicated on Side 1 of this document.
- I understand that this authorization shall operate as a complete release of liability to Southern Ocean County Hospital, its trustees, officers, agents and employees for release of information as specified on Side 1 of this document.
- I understand that if I disclose my health information to anyone other than the person/agency as indicated on Side 1 that I cannot hold SOCH responsible for that release.
- I understand that once SOCH discloses my health information to the recipient, SOCH cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that SOCH may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.
- I understand that I may refuse to sign or may revoke this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at SOCH; except, however, if my treatment at SOCH is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case SOCH may refuse to treat me if I do not sign this Authorization.
- I understand that this Authorization will remain in effect for four (4) months from the date of my signature or if I provide a written notice of revocation to SOCH's Privacy Office at the address listed above. The revocation will be effective immediately upon SOCH's receipt of my written notice, except that the revocation will not have any effect on any action taken by SOCH in reliance on this Authorization before it received my written notice of revocation.

Copying fees are in accordance with New Jersey Department of Health Regulation 8:43G-15.3

- The fee for copying records shall not exceed \$1.00 per page or \$100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of not more than \$0.25 per page may be charged for pages in excess of the first 100 pages up to a maximum of \$200.00 for the entire medical record.
- A search fee of no more than \$10.00 per patient per request.
- A postage charge of actual costs for mailing.

I have read and understand the terms of this Authorization. By my signature below, I hereby, knowingly and voluntarily, authorize SOCH to use or disclose my health information in the manner described above.

Signature of Patient

Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative

Date

Description of Authority

Identification Verified by: _____
(SOCH Representative)

(If SOCH has requested an authorization for disclosure by others, provide a copy of signed Authorization to the patient.)

*This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2).