Cooper University Hospital

AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

I, _____, hereby authorize Cooper University Hospital to use the health information about me
(*Print Name*)
that is specified below, and to disclose such health information to

_____
(Identification of recipient, address, telephone number)
for the following purposes:

_____.

If the above purpose(s) includes the use or disclosure of your health information for Cooper University Hospital's marketing purposes, or another entity's marketing, Cooper University Hospital **will/will not** be paid, either directly or indirectly, for using or disclosing your health information for such marketing purpose(s).

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO THIS AUTHORIZATION

Date(s) of Service _____

[ ]	Admission Record	[ ]	Operative Reports	[ ]	AIDS or HIV-related information
[ ]	Discharge Summary	[ ]	X-Rays	[ ]	Other (specify)_____
[ ]	Emergency Department Record	[ ]	Laboratory Results		
[ ]	History and Physical Consultation(s)	[ ]	Psychiatric Records		
[ ]	Pathology Report(s)	[ ]	Drug abuse and/or alcoholism treatment records		
[ ]	Consultations				

This authorization will expire on _____ or when the following event happens:
_____.

This authorization will automatically expire one year from the date it is given. An authorization for disclosure of psychiatric records will automatically expire 60 days from the date it is given.

I understand that I may revoke this authorization at any time, even if it has not expired, by giving a written notice to the Director of Health Information Management. I understand that my revocation will become effective on the day it is received by Cooper University Hospital. I also understand that Cooper University Hospital may, under certain circumstances, have a continued right to use or disclose my health information if Cooper University Hospital has already used or disclosed the information on the basis of this authorization.

I understand that if I am giving this authorization as a condition of receiving insurance coverage, Cooper University Hospital may have access to health information about me if there is a question about a claim I made under the insurance policy. I understand that a full description of other rights that I may have in regard to a revocation of this authorization can be found in Cooper University Hospital's Notice of Privacy Practices.

Notice to the Individual Giving This Authorization

Your failure to give this authorization may result in the withholding of treatment or services from you, if the treatment is research-related or if the services were to be provided only for the purpose of creating health information about you.

This Authorization shall operate as a complete release of liability of Cooper University Hospital, its trustees, officers, agents and employees for the release of information as specified above.

Once Cooper University Hospital discloses information on the basis of this authorization, we have no control over the recipient's use of the information. The person to whom we disclose your information may disclose it to someone else, and Cooper University Hospital will no longer be able to protect the information.

_____ _____

Patient Signature *Date* *Authorized Representative* *Date*

_____ _____

Print Name *Print Name* *Relationship to Patient*

Address:_____ Patient's Date of Birth:_____