# The Cooper Health System
## AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

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

_____

*Name of the recipient (i.e. patient or representative), address, and telephone number for the following purposes:*

_____

_____

*Name of the health care provider, address, telephone number and fax number*

**Date of Appointment:** _____

_____

**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 | [ ] | Health Information Exchange | | |

**Cooper Fax # 856-342-2687**

This authorization will expire on _____ or when the following event happens: _____.
(*Date*)
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 The Cooper Health System. I also understand that The Cooper Health System may, under certain circumstances, have a continued right to use or disclose my health information if The Cooper Health System 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, The Cooper Health System 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 The Cooper Health System'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 The Cooper Health System, its trustees, officers, agents and employees for the release of information as specified above.

Once The Cooper Health System 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 The Cooper Health System will no longer be able to protect the information.

_____ _____

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

_____ _____

*Print Name* *Print Name* *Relationship to Patient*

*Address/Phone #* _____ *Patient's Date of Birth:* _____