Hunterdon Hematology Oncology, LLC
2100 Wescott Dr. Flemington, NJ 08822
p: 908-237-1201 fax:908-237-1210
www.HunterdonCan.com

# Authorization for Disclosure of Protected Health Information

I,__________________________hereby authorize: __________________________________
(Patient/Guardian/Power of Attorney) (Healthcare Facility/Doctor's Office)

to disclose information in the form of health records for: ______________________________
(Patient's Name)

__________________
(Patient's Date of Birth)

**Health records released to:** **Hunterdon Hematology Oncology, LLC**
**Hunterdon Regional Cancer Center**
**2100 Wescott Drive**
**Flemington, NJ 08822**

**Fax number: 908-237-1210**

**Attention to: _________________________**

- ☐ **Please allow the use of my medical records for research**
- ☐ **Please release my entire medical record**
- ☐ **Please only release the specific items listed below:**

  - _____________________________________________________
  - _____________________________________________________
  - _____________________________________________________

Having read the above information, I release Hunterdon Healthcare System, its employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of information set forth by this request related to my Protective Health information

I understand that this authorization will remain in effect for 1 year or until I provide a written notice of revocation to Hunterdon System's Privacy Office at the address listed in the header above. The revocation will be effective immediately upon receipt of written notice.

__________________________________________________ ____________________
(Patient, *Parent, *Guardian or *Power of Attorney Signature) (Date)

__________________________________________________ ____________________
(Witness Signature) (Date)

*If this form is being completed by a Power of Attorney/Parent/Guardian, please complete the following:

- ☐ Patient is a minor__________________________years of age
- ☐ Patient is unable to sign due to ___________________________________________