NEW JERSEY DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I, ____, hereby authorize

____
(Name of treating physician)

____
(Street Address, PO Box, Suite)

____
(City, State, Zip)

to disclose my individually identifiable health information, as described below, to:

New Jersey Department of Human Services
DHS Central Office ADA Coordinator/Division or institution ADA Coordinator
____
P.O. Box _________________________
_______________________________, New Jersey ___________
(   ) _____ - _____________

All information, including summaries, evaluations, treatment notes or other records or information dating from ____ to ____,
(Onset of Medical Condition) (Present Date)

that relates to the medical condition(s) ____.
(Specify Medical Condition(s))

The purpose of this authorization is to verify the medical condition which underlies my request for a reasonable accommodation. I also authorize the treating physician named above to complete any forms required by the New Jersey Department of Human Services, and if necessary, to speak with an ADA Coordinator of the New Jersey Department of Human Services about my condition and request for a reasonable accommodation.

This authorization will expire ________________________ (e.g., 60 days) from the day of my signature below.

I understand that I may revoke this authorization at any time by notifying the treating physician, named above, in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.

I have executed this authorization voluntarily, and I understand that the treating physician cannot condition treatment, payment, enrollment or eligibility for benefits based on the signing of this authorization, unless the authorization is (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.

I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the treating physician named above if the recipient of the information is not a health plan, health care provider, or healthcare clearinghouse.

______________________________ ______________________

Signature of individual requesting accommodation Date

____

Printed name of person making request