



**THE VALLEY HOSPITAL**  
4 Valley Health Plaza  
Paramus, New Jersey 07652-3619  
201-447-8111  
201-447-8648 Fax

## Authorization for Release of Medical Records

Rev. 04/24  
1 of 2

**Upcoming Doctor's Appt Date/Time:** 11/04/2024

### Section A: This must be completed for all Authorizations

|                                                                                                                                                                                                                                                                   |              |                              |                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------|------------------------------------|
| Patient Name:<br>Akiva Anachovich                                                                                                                                                                                                                                 |              | Date of Birth:<br>12/25/1951 | Patient's Phone:<br>(201) 679-5063 |
| Recipient's Name:<br>Akiva Anachovich                                                                                                                                                                                                                             |              |                              |                                    |
| Recipient's Address:<br>39-28 Pershing street                                                                                                                                                                                                                     |              |                              | Recipient's Phone:                 |
| City:<br>Fair Lawn                                                                                                                                                                                                                                                | State:<br>NJ | Zip:<br>07410                |                                    |
| <b>Request Delivery method (if left blank, a paper copy will be provided):</b> <input type="checkbox"/> Paper Copy <input type="checkbox"/> Pick Up ( <u>at Ridgewood Campus, see page 2</u> )*<br><input type="checkbox"/> Electronic Image Sharing (see page 2) |              |                              |                                    |
| <b>Email:</b> <input type="checkbox"/> Encrypted <input checked="" type="checkbox"/> Unencrypted <b>CD:</b> <input type="checkbox"/> Encrypted <input type="checkbox"/> Unencrypted <input type="checkbox"/> Fax # _____                                          |              |                              |                                    |
| *Medical records prior to 2015 will be sent to the patient portal.                                                                                                                                                                                                |              |                              |                                    |
| <b>Email Address (if email checked above. Please print legibly):</b><br>aakiva1@gmail.com                                                                                                                                                                         |              |                              |                                    |

This Authorization will expire on the following: (Fill in the Date or the Event but not both. If Date or Event not filled out, authorization will expire 1 year after date of signing): **Date:** 11/03/2025 **Event:** \_\_\_\_\_

**Purpose of release:** ☐ Facility/Physician Disclosure **Physician Name:** \_\_\_\_\_  
☐ Treatment ☐ Personal Use ☐ Legal ☒ Other: Second Opinion (Treatment)

### Description of information to be used or disclosed (please check all that apply and include date(s) as applicable)

| Type of Information:                                             | Date(s) of Visit:        | Type of Information:                              | Date(s) of Visit:                                                                              |
|------------------------------------------------------------------|--------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Abstract                     | 11/03/2023 to 11/03/2024 | <input type="checkbox"/> Recovery & Wellness Unit |                                                                                                |
| <input checked="" type="checkbox"/> Emergency Room Visit/test(s) | 11/03/2023 to 11/03/2024 | <input checked="" type="checkbox"/> Lab Results   | (please specify)<br>Laboratory Tests, EKG Report, Pathology Report<br>11/03/2023 to 11/03/2024 |
| <input type="checkbox"/> Entire Chart * See instructions         |                          | <input checked="" type="checkbox"/> Images        | (please specify)<br>11/03/2023 to 11/03/2024                                                   |
| <input type="checkbox"/> Bone Density                            |                          | <input checked="" type="checkbox"/> Other:        | (please specify)<br>Mammography Report<br>11/03/2023 to 11/03/2024                             |
| <input checked="" type="checkbox"/> CT                           | 11/03/2023 to 11/03/2024 |                                                   |                                                                                                |
| <input checked="" type="checkbox"/> MRI/MRA                      | 11/03/2023 to 11/03/2024 |                                                   |                                                                                                |
| <input checked="" type="checkbox"/> PET                          | 11/03/2023 to 11/03/2024 |                                                   |                                                                                                |
| <input checked="" type="checkbox"/> Ultrasound                   | 11/03/2023 to 11/03/2024 |                                                   |                                                                                                |
| <input checked="" type="checkbox"/> X-Ray                        | 11/03/2023 to 11/03/2024 |                                                   |                                                                                                |
| <input checked="" type="checkbox"/> Echo                         | 11/03/2023 to 11/03/2024 |                                                   |                                                                                                |

I acknowledge that if any of the above checked health information contains alcohol/drug abuse/use and related treatment, genetic information, mental/behavioral health, tuberculosis, sexually transmitted disease, HIV testing, HIV/AIDS results and related information, and/or any communication or information regarding reproductive health services information, ("Sensitive Information"), such Sensitive Information will be disclosed to the above recipient. subject to the requirements in A.10 of the Instructions, and I hereby consent to disclosure of such information.

I understand that:

1. I may refuse to sign this Authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits shall not be conditioned on signing this Authorization.
3. I may revoke this Authorization at any time in writing, by sending my written revocation to The Valley Hospital, Inc. 4 Valley Health Plaza, Paramus, NJ 07652-3619, Attn: Compliance Officer. I further understand that my revocation of this Authorization will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations and may be re-disclosed by the recipient. State law limiting re-disclosure of specifically protected categories may continue to apply to any recipient of such information.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I understand the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, and other state and federal laws, as may be amended from time to time.
7. I can get a copy of this Authorization after I sign it.

### Section B: Signatures - Please sign below.

I have read the above and authorize the disclosure of my Medical Record as described in this Authorization.

|                                                                                    |                                          |
|------------------------------------------------------------------------------------|------------------------------------------|
| <b>Signature of Patient/Patient's Representative:</b>                              | <b>Date:</b> 11/03/2024                  |
| <b>Print Name of Patient's Representative: (Ex: POA, Executor, Legal Guardian)</b> | <b>Representative Authority:</b><br>Self |
| <b>Name of Person Other than Patient Picking up Records:</b>                       | <b>Relationship to Patient:</b>          |

Authorization for Release  
of Medical Records

Rev. 04/24  
2 of 2

**\*Medical record pick-ups will be at the Ridgewood campus:  
HIM Department, 223 N. Van Dien Avenue, Ridgewood, NJ 07450**

**Directions for Completing the Authorization to Release Information**

**\*\*\*Note: Release of information will occur after hospital discharge**

**Section A:**

1. Provide the patient's name, date of birth, and phone number.
2. Provide the name of the recipient (receiver) of the information. The recipient is whoever is going to receive the records. The recipient of the information may be someone other than the patient. It may be the patient's spouse, parent, power of attorney, another healthcare provider, etc. If the recipient's name is the same as the patient, just write "SELF."
3. If the recipient is the patient, provide the address of the patient. If the recipient is different than the patient, provide the address and phone number of the recipient.
4. Next check the method of delivery: paper copy, electronic copy (CD) or electronic image sharing, (vascular lab, CT, mammo, MRI/MRA, x-ray, bone density, PET, ultrasound, nuclear medicine), email or pick up. If you want the information faxed, indicate the fax number. If you choose the option to send to the patient portal, please sign up for the portal separately if you do not already have access (images cannot be sent to the portal). If by email, provide the email address. When requesting medical records to be sent unencrypted via email or CD, your health information is not protected from unauthorized access. If you choose to receive emails in an unencrypted manner, there is an increased chance and you accept the risk that your health information could be compromised if emails are lost in transmission, hacked by a third party or accessed by the wrong recipient.
5. **NOTE:** If the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).
6. **Any information not picked up within 5 business days once completed will be mailed to address provided.**
7. Indicate when this form expires. Put a date or an event (event example: the end of my outpatient therapy), but not both. If no date or event is listed, the authorization will expire 1 year after date of signature.
8. Provide the reason for disclosure, examples are: further treatment, insurance purposes, for attorney, personal use, etc.
9. At **DESCRIPTION** indicate what information you are requesting. Most common is the abstract, which contains the discharge summary, history and physical, ER report, consults and operative reports from the physicians, along with test results such as labs, radiology, and pathology. Please indicate the dates of service.
10. **SENSITIVE INFORMATION REQUIREMENTS:** Sensitive Information that may be in your record will generally be released along with any record request made pursuant to this Authorization. For example, an HIV positive test result would be released if the Lab Results box was checked. However, Recovery & Wellness Unit (inpatient substance use treatment unit) records will not be included in any request unless the "Recovery & Wellness Unit" box is selected. If requesting the "Entire Chart" and you wish to also include Recovery & Wellness Unit records related to inpatient substance use treatment, both the "Recovery & Wellness Unit" box and the "Entire Chart" box must be checked off.
11. **There may be a copy fee for the information you requested. Most requests will be sent to our copy service called MRO Disclosure Management Solutions. Their contact information to ask questions, check status, or make a payment is 888-252-4146, Option 1, Fax: 610-962-8421, or Email: requestinformation@mrocorp.com.**
12. This authorization shall not be used to disclose protected health information for marketing purposes and/or the sale of protected health information.
13. A separate authorization is needed to authorize disclosure of Recovery & Wellness Unit records for use in civil, criminal, administrative or proceedings against the patient and cannot be combined with an authorization to release such records for any other purpose.

**Section B:**

1. The patient must sign and date the form. OR,
2. The patient's LEGAL representative must sign and date the form. **Examples of appropriate "Representative Authority" include but are not limited to: power of attorney, legal guardian, or healthcare surrogate. (A spouse is not a LEGAL representative unless they have LEGAL power of attorney or healthcare surrogacy paperwork.) A copy of the LEGAL paperwork must be submitted with this request.**
3. Patients over 18 years of age must request their own records, unless otherwise legally unable to sign this authorization.
4. Please send a copy of the patient's ID or the legal paperwork mentioned above, along with this request, to the HIM Department via fax at 201-447-8648, or email to himdept@valleyhealth.com

Akiva Anachovich (D.O.B. 12/25/1951)

Deadline: 11/04/2024

Additional Identifiers Requested

**1. Driver's License**



**2. Mailing Address**

39-28 Pershing street

Fair Lawn, NJ 07410

**3. Email Address (user confirmed)**

aakiva1@gmail.com (consented to an emailed copy of their request)

**4. Phone Number (verified)**

(201) 679-5063 ✓

**5. Signature**

A handwritten signature in black ink, appearing to read 'Akiva Anachovich'.

**REASON FOR REQUEST**

Second Opinion (Treatment)

**NOTE: TIME SENSITIVE**

I have a need for my records on this date: 11/04/2024

|           |                                  |                                                                    |
|-----------|----------------------------------|--------------------------------------------------------------------|
| SENT      | 11/03/2024<br>11:44:41 GMT-05:00 | Sent for signature to Akiva Anachovich<br>(aakiva1@gmail.com)      |
| VIEWED    | 11/03/2024<br>11:44:43 GMT-05:00 | Viewed by Akiva Anachovich (aakiva1@gmail.com)<br>IP: 173.63.68.53 |
| SIGNED    | 11/03/2024<br>11:45:48 GMT-05:00 | Signed by Akiva Anachovich (aakiva1@gmail.com)<br>IP: 173.63.68.53 |
| COMPLETED | 11/03/2024<br>11:45:50 GMT-05:00 | The document has been completed. (Request ID:<br>BWOJB9MB)         |