Saint Clare's Health System
Jersey Health Connect - Health Data Exchange
Authorization Form for Third Party Personal Health Record Access

Patient Name:_____ D.O.B:_____

Last 4 digits of S.S. #:_____ Telephone #:_____

I, the undersigned, hereby authorize Saint Clare's Health System and Jersey Health Connect, Saint Clare's Health System's trusted HIPAA Business Associate, **to permit my family member, relative, friend or other individual identified below** a "PHR User" **access to my** online **Personal Health Record** ("PHR") which contains my Health Information. By signing this authorization, I understand that the PHR User I designate below will have access to **ALL** of my Health Information that **may** be contributed by Saint Clare's Health System, my doctors and other health care providers who participate in Jersey Health Connect. This includes Health Information that exists *now*, and Health Information that may be created *in the future*.

Designate PHR User information below:

Name of PHR User: _____

Email address of PHR User: _____

For purposes of this authorization, "**Health Information"** includes: any and all information related to my care and treatment by my health care providers, such as demographic and billing information, insurance and payment information, admission/discharge dates, current and past diagnoses, medications, allergies, and treatment provided. I understand that my Health Information may **also** contain, now or in the future, certain "**Sensitive Information**" which may include any and all legally-protected information relating to (a) a diagnosis or suspected diagnosis of HIV/AIDS, (b) sexually transmitted diseases, (c) mental health records, (d) drug and alcohol treatment information, (e) genetic information, and (f) other care or services that the law requires my prior written consent for.

I understand that I can change my mind at any time by contacting Jersey Health Connect (telephone # 855-624-6542). However, I understand that any information accessed or disclosed to the identified PHR User before my Withdrawal is processed cannot be reversed or undone.

By signing below, I acknowledge that I have read this authorization and understand and agree with all of the information presented here. I acknowledge that the terms of this authorization are, in part, governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as may be amended from time to time ("HIPAA"), as well as New Jersey law. I understand that Jersey Health Connect and my health care providers are not responsible for any re-disclosure of my Health Information, including Sensitive Information, which may be made by any PHR User I hereby designate. I understand that this authorization shall be durable and continue in effect until I withdraw it.

_____ Date: ____/_____/_____

Patient or Legal Representative Signature

If legal representative, sign below and state relationship and authority to do so and attached the document of authority.

Relationship: _____ Date: ____/_____/_____

Witness: _____ Date: ____/_____/_____