

MRN: _____

**WELCOME TO THE SUMMIT MEDICAL GROUP
HEALTH INFORMATION MANAGEMENT SERVICES
DEPARTMENT**

***PLEASE READ THE FOLLOWING INSTRUCTIONS TO REQUEST A COPY
OF YOUR MEDICAL RECORDS***

***HOURS: 9:00am – 5:00pm Monday through Friday
FOR COPIES OF YOUR X-RAYS, PLEASE SPEAK TO THE RADIOLOGY
DEPARTMENT AT (908) 277-8673***

1. Please obtain a copy of our “Authorization to Use and Disclose Health Information” form. These forms are available at each of our offices and on our Web Site. Upon completion, you may mail or fax this form to Summit Medical Group. Instructions are included on the form.

2. **Please take note of the following:**
 - A. Our normal turn around time to complete your request is **two weeks**.
 - B. If you are a patient requesting copies to be sent to you, there is a fee of \$5.00 for pages 1 through 10. Each page thereafter will be charged at \$1.00 per page up to a maximum of \$100.00.
 - a. Once your records are copied, you will be billed. Upon payment you will receive your copies. You also have the option of paying with a credit card. Visa, MasterCard and American Express are acceptable, please fill out the form marked “Credit Card Charges”
 - b. If you intend to pick up your copies of medical records, you must indicate “Pick Up” on your authorization form. **YOU WILL BE CALLED WHEN YOUR COPIES ARE READY FOR PICK UP.** Payment is expected at the time of pick up. You may include a check made out to *Nova Records Management* or charge this to your credit card. **WHEN PICKING UP RECORDS, ONLY THE PATIENT OR AUTHORIZED REPRESENTATIVE MAY PICK UP THE RECORDS. PROOF OF ID IS REQUIRED.**
 - C. Initial record request for copies to be sent to a physician who is not part of Summit Medical Group will be copied no charge. Records **MUST** be mailed directly to your physician. If for some reason, such as incorrect address, etc., these records are NOT received by the physician’s office and an **ADDITIONAL** copy is needed to be made, **THERE WILL BE A CHARGE.**

REMEMBER, YOUR AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION MUST BE FILLED OUT COMPLETELY. INCOMPLETE REQUESTS (SUCH AS INCOMPLETE ADDRESS INFORMATION) WILL NOT AND CANNOT BE HONORED. INCORRECT ADDRESS INFORMATION WILL ONLY DELAY RECEIPT OF RECORDS AND MAY REQUIRE PAYMENT FOR A SECOND SET OF COPIES. REMEMBER TO SIGN AND DATE THE REQUEST. MEDICAL RECORDS WILL NOT BE FAXED. A CHARGE, AS STATED ABOVE, WILL BE INCURRED, FOR ANY ADDITIONAL COPIES MADE.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____
Street Address

City State Zip Code
Telephone: (Day) _____ **(Evening)** _____ **Date of Birth:** _____

Please send form to: Medical Records Department
1 Diamond Hill Road
Berkeley Heights, NJ 07922
Phone 908-790-6520 Fax 908-790-6598

SPECIFY INFORMATION TO BE DISCLOSED: _____

RELATING TO THE TIME PERIOD _____ **through** _____

Note: If your health information contains any genetic, HIV/AIDS-related (i.e., information regarding any HIV related test, infections or illness including AIDS), venereal disease and/or tuberculosis information, you must specifically mention "genetic information", "HIV/AIDS-related information", "venereal disease information" and/or "tuberculosis information" if you want Summit Medical Group to disclose such information to any person other than you or your personal representative.

RECIPIENT: To whom Summit Medical Group may disclose my health information:

Name _____
Company _____
Address _____

🍏 I WILL PICK UP RECORDS AT 150 FLORAL AVE., NEW PROVIDENCE, NJ

(If information goes to patient, specify address if different than the one written above.)

PATIENT ACCESS TO INFORMATION:

- I wish to view the requested information.
- I would like to obtain a copy of the information specified above.
- I would like to obtain a summary of the requested information prepared by the Summit Medical Group at a cost to me of \$20.00 per hour and \$1.00 per page.

TERM: This authorization will remain in effect until the request has been fulfilled unless otherwise noted. _____

Purpose of disclosure:

- At the request of the patient (when the patient initiates the authorization)
- Other (please specify) _____

MRN: _____

I understand that once Summit Medical Group discloses my health information to the recipient, Summit Medical Group cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Summit Medical Group’s treatment of me except however, if Summit Medical Group’s treatment of me is for the sole purpose of creating PHI for disclosure to the third person, in which case, Summit Medical Group may refuse to treat me if I do not sign this Authorization.

I understand that Summit Medical Group may deny my request to have access to my information under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request to have access to my information reviewed by a licensed health care practitioner selected by Summit Medical Group who did not participate in Summit Medical Group’s decision to deny my request.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Summit Medical Group. The revocation will be effective immediately upon Summit Medical Group’s receipt of my written notice, except that the revocation will not have any effect on any action taken by Summit Medical Group in reliance on this Authorization before it received my written notice of revocation.

COPY FEES: If copy fees are applicable, they will be applied according to New Jersey state mandate.

The address of Summit Medical Group’s Patient Relations Coordinator is 1 Diamond Hill Road, Berkeley Heights, NJ 07922, and I may contact the Patient Relations Coordinator by telephone at 908-273-4300 or by email at wecare@smgpa.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature I hereby, knowingly and voluntarily, authorize Summit Medical Group to use or disclose my health information in the manner described above.

Signature of Patient

Date

If Patient is a minor or is otherwise unable to sign this Authorization, please obtain the following signatures:

Signature of
Personal Representative

Description of Personal Representative’s Authority
(i.e. POA, legal guardian- documentation required)

Date

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Authorization to Charge Credit Card

- I _____, request that copies of my medical records be provided. I understand that if I am requesting these records to be provided to me, I will be charged.
- **The charges are as follows: 1-10 pages, \$5.00 plus \$1.00 per page thereafter with a maximum charge of \$100.00**
- I understand that normal turnaround time is approximately two weeks. I also understand that Summit Medical Group /Nova Records Management cannot specify my exact charges until the work is completed.

I authorize **Nova Records Management** to charge my credit card for copies of my medical records.

Cardholder's Name: _____

Visa _____ MasterCard _____ American Express _____

Credit Card #: _____ (please print clearly)

Expiration Date: _____

Cardholder's Signature: _____

All Credit Card Charges Will Be Processed By

Nova Records Management
732-698-9950

**Please Return This Form With Your
“Authorization To Use and Disclose Health Information”**

TO:

**Summit Medical Group
Medical Records Department
1 Diamond Hill Road
Berkeley Heights, NJ 07922**