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 complete the “Authorization to Use and Disclose Health Information” form. You may mail or fax this form to SMG.

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. You will receive your copies upon payment. 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 Cornerstone Records Management, who provides medical record copying service for SMG, 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 at 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.
   D. You also have the right to request a copy of your medical record in electronic form. You will be provided with an electronic copy of your health information, which includes diagnostic test results, problem list, medication lists, and medication allergies, within three business days. PLEASE NOTE: The electronic copy will only include the information specified above. If you need a complete copy of your record, you should make a request in accordance with the process listed above. Also, please be aware that if you do not pick up the electronic copy within 60 business days, the electronic copy will be discarded.
AUTHORIZATION TO USE AND DISCLOSE PROTECTED 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: Summit Medical Group
Health Information Management Services
150 Floral Avenue
New Providence, NJ 07974
Phone 908-273-4300 (ext. 2929)                       Fax 908-790-6598

The following Health Information about me may be used and disclosed (check each box that applies):

☐ My entire medical record ☐ Mental Illness
☐ HIV/AIDS Testing, Diagnoses, & Treatments
☐ My entire medical record ☐ Mental Illness
☐ Genetec Testing Results
☐ Drug or Alcohol Addiction Diagnoses or Treatments
☐ HIV/AIDS Testing, Diagnoses, & Treatment
☐ Psychotherapy Notes
☐ Other
☐ Sexually Transmitted Disease Testing, Diagnoses, & Treatment
☐ Other

RELATING TO THE TIME PERIOD ____________________ through __________________________

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

Name ________________________________________________________________
Company _____________________________________________________________
Address ______________________________________________________________

☐ PLEASE MAIL MY RECORDS TO THE RECIPIENT LISTED ABOVE

☐ PLEASE MAIL MY RECORDS TO ME AT MY HOME ADDRESS

☐ I WILL PICK UP RECORDS AT 150 FLORAL AVENUE, NEW PROVIDENCE, NJ:

TERM: This authorization will expire upon SMG’s release of my Health Information as needed to fully accomplish the purpose(s) listed below or 90 days from the date signed.

PURPOSE OF DISCLOSURE:

☐ At the request of the patient (when the patient initiates the authorization)

☐ Other (please specify) ________________________________
It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used and disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal and/or state confidentiality rules.

I hereby release SMG and/or Cornerstone from any liability which may result from this disclosure of medical information, or which may arise as a result of the use of information contained in the information released.

I understand that I have the right to revoke this Authorization, at any time before SMG’s reliance thereon, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in SMG’s Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

Summit Medical Group, P.A.
150 Floral Avenue
New Providence, New Jersey 07974
Attn: Legal Services/Privacy Officer

To check the status of your records request, please contact Cornerstone Customer Service at 866-985-2112.

If you have any concerns, you may contact the manager of HIMS at 908-790-6507 or the Privacy Officer at 908-790-6558.

_____________________________  ______________________
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 Date
(i.e. POA, legal guardian- documentation required)
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 SMG/Cornerstone Records Management cannot specify my exact charges until the work is completed.

I authorize Cornerstone 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

Cornerstone Records Management
732-698-9950

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

TO:

Summit Medical Group
Health Information Management Services
150 Floral Avenue
New Providence, NJ  07974