SUMMIT MEDICAL GROUP

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

_____
City State Zip Code

Telephone#:_____ Alt. Telephone#:_____Date of Birth :_____

Please Release Records To:

Name: _____Organization: _____

Address:_____Phone: _____

_____ Fax: _____
City State Zip

Release the following*: (If no date of service provided, 1 year of records will be sent.)*

Dates of Service _____ to _____ Provider/Specialty: _____

Check all boxes that apply:
☐ Abstract Record (Last year of encounters and procedures, lab results, and imaging/diagnostic results)
☐ Entire Record (All records available for dates requested above)
☐ Encounter and Procedures ☐ Consultation ☐ Lab results ☐ Imaging/Diagnostic results ☐ Immunization record
Other: _____
Please include: ☐ Itemized Billing Statement ☐ Behavioral Health Notes ☐ Radiology Images (CD Only)

Purpose for the Request: ☐Continuation of Care ☐Attorney/Legal ☐Insurance ☐ Personal Use

☐ Other_____

Format: ☐Paper ☐CD ☐Electronic ☐Thumb-drive (USB)

Delivery Method: ☐Mail ☐ Pick-up (notified when available) ☐Electronic ☐ Fax (providers only)

I, the undersigned authorize SMG and/or their business partners to release information from my medical records as described above.

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I understand and acknowledge that the medical record may contain information regarding **psychiatric disorders, human immune virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependency abuse, and genetic testing.**
If you wish not to release any of the above-mentioned information, please indicate below; otherwise, this information may be disclosed.

Do not release the following: _____

I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to:
Summit Medical Group P.A.
121 Chanlon Road,
New Providence, New Jersey 07974
Attn: Privacy Officer.
I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days from the date signed.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand and accept that by law you have 30 days to comply with my request.

I understand there may be charges for the copying and release of information and accept financial responsibility.

Signature of Patient: _____ Date: _____
(If 18 years or older or is an emancipated minor)

Signature of ☐Parent ☐Legal Guardian _____ **Date: _____**
Note: If legal guardians checked, documentation establishing relationship must be provided.

Please send the completed form to:

Summit Medical Group
Health Information Management Services
150 Floral Avenue
New Providence, NJ 07974
Ph.: 908-790-6520 Fax: 908-790-6598