SUMMIT MEDICAL GROUP
1 Diamond Hill Road, Berkeley Heights, NJ 07922
summitmedicalgroup.com

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

WELCOME TO THE SUMMIT MEDICAL GROUP (SMG)
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 complete the "Authorization to Use and Disclose Health Information" form. You may mail or fax this form to SMG.

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2. **Please take note of the following:**

   A. We will complete your request within thirty days.

   B. If you are a patient requesting copies to be sent to you, there is a fee of $1.00 for each page copied, up to a maximum of $100.00.

      a. Once your records are copied, you will be billed.

      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 (Mastercard, Visa, or Discover is accepted). **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.

   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
Fax 908-790-6598

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

☐ **My entire medical record** ☐ **Office visit notes** ☐ **Diagnostic test results**

☐ **Itemized Billing Statement** ☐ **Radiology Studies (MRI, X-ray, etc.)**

If your information contains any information listed below, you must check the appropriate boxes in order to have the information released.

☐ **Mental Health Diagnosis & Treatment**
☐ **HIV/AIDS Testing, Diagnoses, & Treatment**
☐ **Sexually Transmitted Disease Testing, Diagnoses, & Treatment**
☐ **Drug or Alcohol Addiction Diagnoses or Treatment**
☐ **Genetic Testing Results**
☐ **Other** _____

FOR THE FOLLOWING SPECIALTY OR PROVIDER: _____**; OR**
ALL SPECIALTIES OR PROVIDERS SEEN AT SMG: _____ **(initial here)**
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 07974**

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 un-authorized re-disclosure and the information may not be protected by federal and/or state confidentiality rules.

I hereby release SMG and/or Iron Mountain 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.
121 Chanlon Road
New Providence, New Jersey 07974
Attn: Legal Services/Privacy Officer

To check the status of your records request, please contact Iron Mountain at 732-651-2802.

If you have any concerns, you may contact the HIMS Department at 908-273-4300 (x2929) or the Privacy Officer at 908-977-9497.

_____ _____
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