

Summit Medical Group

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: M Copy Request Inc.  
I Summit Medical Group  
S 1 Diamond Hill Road  
F Berkeley Heights, NJ 07922

SPECIFY INFORMATION \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 120 SUMMIT AVENUE BUILDING  
(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) \_\_\_\_\_

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 120 Summit Avenue, Summit, NJ 07901, and I may contact the Patient Relations Coordinator by telephone at 908-273-4300 or by email at [wecare@smgpa.com](mailto: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