Morristown
Cardiology Associates, P.A.

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Morristown Cardiology Associates, P.A. Medical Record Copy Request Policy

Medical Record Department Hours: 8:30 am to 5:00 pm, Monday through Friday

1. Attached is our "Authorization to Use and Disclose Health Information" form. This form is available at our office and on our website; www.morristowncardiology.com. Upon completion, you may mail or fax this form to our office (Fax # 973-455-0399).

2. Please take note of the following:

- Our normal turnaround time to complete medical records requests is 10 business days for current patients and 15 business days for patients not seen at our office for 2 or more years.

- If you are a patient requesting copies to be sent to you, there is a fee. The schedule of fees can be found on the "Authorization to Charge Credit Card" form.

    - 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, American Express and Discover are acceptable, please fill out the form marked "Authorization to Charge Credit Card." (Form on reverse of this information sheet.)

    - If you intend to pick up a copy of your medical records, check the appropriate box on the authorization form. YOU WILL BE CALLED WHEN YOUR COPIES ARE READY FOR PICK UP. Payment is expected at the time of pick up. Make your check payable to:

    Morristown Cardiology Associates, P.A. or charge to your credit card.

• Initial record request for copies to be sent to your primary care physician 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 needs to be made, THERE WILL BE A CHARGE.

Remember, your "Authorization to Use and Disclose Health Information" form 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 to patients. MCA only faxes records to physicians. A charge, as stated above, will be incurred, for any additional copies made.

Morristown Cardiology Associates, P.A.

Authorization to Charge Credit Card

- Date of Request: _____

- 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 a fee.

- The charges are as follows:

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	Medical Record Copies: $1.00 per page for the first 100 pages, .25 cents for every additional page with a maximum charge of $200.00. There will be an additional charge for postage if record exceeds 10 pages.

- I understand that normal turnaround time is approximately one week. I also understand that Morristown Cardiology Associates, P.A. cannot specify charges until the work is completed.

I authorize Morristown Cardiology Associates, P.A. to charge my credit card for copies of my medical records.

Cardholder's Name: _____

(Circle card type) Visa Master Card American Express Discover

Credit Card #: _____

Expiration Date: _____/_____/_____ Card Verification Code: _____
(3-4 digit code on front or back of card)

Cardholder's Signature: _____

Date of Signature: _____

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

TO:

ATTN: Medical Records
Morristown Cardiology Associates, P.A.
435 South Street, Suite 100
Morristown, NJ 07960

973-267-3944
973-455-0399 (fax)
435 South Street, Suite 100
Morristown, NJ 07960

MORRISTOWN CARDIOLOGY ASSOCIATES, P.A.

AUTHORIZATION
TO DISCLOSE PARTICIPANT HEALTH INFORMATION

Participant Name:_____

Address:_____

Date of Birth: _____ Date of Request:_____

As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without participant authorization.

I hereby authorize Morristown Cardiology Associates, P.A. and its employees to disclose my Protected Health Information to the following person, health care provider, or business associate:

_____

Participant Health Information authorized to be disclosed:

Blood Pressure Monitor - dated _____

Doppler Study – dated _____

Echocardiogram – dated _____

Echo/Stress – dated _____

Nuclear scan – dated _____

EKG – dated _____

Holter Monitor – dated _____

Sestamibi – dated _____

Stress test – dated _____

Medical Records (be specific)_____

For the specific use or purpose of: (describe in detail):

_____

_____

Effective dates: This authorization is valid for 12 months after the date signed by the participant or the participant's representative.

_____ _____

Signature of Participant or Participant's Authorized Representative *Date*

☐ I will pick my records, please contact me at _____ when the record copies are ready

☐ Please mail my records

☐ Send my records via encrypted e-mail to: _____

Please review your Rights described on the back of this form

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.

2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.

3. Inspect a copy of Participant Health Information being used or disclosed under federal law.

4. Refuse to sign this authorization.

5. Receive a copy of this authorization.

6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected participant health information.