Medical Records Request Packet

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. 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 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.

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. Remember to sign and date the request. Medical records will not be faxed to patients. MCA only faxes records to physicians.

Morristown Cardiology Associates
435 South Street
Morristown, NJ 07960
P 973-267-3944 F 973-455-0399

Atlantic Health System
Atlantic Medical Group

Medical Records Request Packet

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 _____

Other 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 next page

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Patient Rights

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. 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 I provide authorization to use or disclose protected participant health information.

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