Saint Michael's Medical Center

Medical Record Request Form

PLEASE CHECK ONE:
- ☐ Email to Authorized person
- ☐ Authorized person will pick up
- ☐ Mail to Authorized person
- ☐ Fax to Authorized person

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide a **VALID PICTURE ID** and **provide all information requested** may invalidate this authorization.

Name of Patient: ______________________ (first) ______________________ (last)

Date of Birth: ______________________ SSN: ______________________

Patient's Address: ____

City: ______________________ State: __________ ZIP: __________

Phone (cell): ______________________ (home): ______________________

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize *Saint Michael's Medical Center*
to release to (Persons/Organizations authorized to receive this information)

Name of Authorized Person/Organization: ______________________

Address: ______________________ City: __________ State: __________ Zip: __________

Phone: ______________________ Fax: ______________________ Email: ______________________

☐ Covering the period of healthcare from ______________ to ______________

Please check the following information requested:

☐ All health information pertaining to my medical history, mental or physical condition, and treatment received. –OR-

☐ Only the following records or types of health information (including any dates):

- ☐ Discharge Summary
- ☐ History and Physical Rehab
- ☐ Rehab
- ☐ Consultations(s)
- ☐ Operative Report
- ☐ ER
- ☐ All pertinent Lab/X-rays/EKG
- ☐ Other: ______________

☐ I specifically authorize release of the following information (initial as appropriate):

- ☐ Mental Health Treatment Information
- ☐ HIV test results
- ☐ Alcohol/drug treatment Information
- ☐ Outpatient psychotherapy notes
- ☐ STD
- ☐ Sexual Assault
- ☐ Child Abuse/Neglect

PURPOSE

Purpose of requested use of disclosure: ☐ Patient request -OR- ☐ other

EXPIRATION

This authorization expires on: ______________________________

PATIENT I.D.

Medical Record Request Form page 2

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to:

Saint Michael's Medical Center
111 Central Avenue
Newark, NJ 07102

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such by federal confidentiality law (HIPPA). However, NJ law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically requested or permitted by law.

Options of Electronic Format: According to HITECH section 13405 (e) (1); 42 U.S.C. 17935 (e) (1), you may have your electron medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be deliver in a note the receiving entity may not accept records in electronic format: ☐ Burn to CD ☐ Paper

SIGNATURE

Date: ______________________ Time: ______________ am/pm

Signature ____________________________________
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient, Lincensed Psycotherapist's approval for geropsychiatric patient:

Witness: ____________________________________

PATIENT I.D.

AUTHORIZATION FOR
USE OR DISCLOSURE
OF HEALTH INFORMATION
PHSI-280-014-SMNJ - Page 2 of 2

Saint Michael's Medical Center

Due to public health concerns related, the Health Information Management Department is closing the office to the public to eliminate person to person contact. We understand your medical records are important to you and want to make this process as smooth as we can during this time.

To expedite your request, please complete the medical record request in its entirely and also provide **a VALID PICTURE ID** . If you have questions on how to complete the request, contact our Health Information Department at 973-877-5115

Ways I can I request my Medical records?

1. Mail in Requests
2. Fax Medical records Request

Where can I send my Medical records Requests?

You may submit the request by mail to:

ST MICHAEL'S MEDICAL CENTER
Attn: Medical Records/ROI
111 Central Avenue
Newark New Jersey 07102

You may also fax the request to: 973-877-5112

What if I am requesting for my Physician and upcoming appointment for continuity of care?
Please have your physician fax request to 973-877-5112 In addition, please note the date needed or appointment date so the request could be expedited. Please ensure you PRINT the Physician's Name clearly and visibly.

When will I / the Third Party receive a copy of my medical record?
Medical record requests are processed within 15 business days from the date the request is received by St Michaels Medical center

You can also call the Release of Information Department for additional information regarding obtaining copies: 973-877-5115

If you should have any further questions or problems, please contact the HIM manager at 973-877-5109. Thank you for your understanding during this time.

HIM Manager

Saint Michael's Medical Center

HEALTH INFORMATION MANAGEMENT (Medical Records)

phone: 973-877-5115 fax: 973-877-5112

Due to public health concerns related, the Health Information Management Department is closing the office to the public to eliminate person to person contact. We understand your medical records are important to you and want to make this process as smooth as we can during this time.

MEDICAL RECORDS ARE PROCESSED WITHIN 15 BUSINESS DAYS FROM THE DATE THE REQUEST IS RECEIVED.

If you are requesting your medical records for an upcoming appointment with your physician:

- Please have your physician FAX the request to 973-877-5112. Remind physician to note the date needed or appointment date.

Process to request Medical Records:

a) Three ways of obtaining *Medical Record Request Form*
   1. Print form from SMMCNJ.com website
   2. Call SMMC Health Information Department 973-877-5115 to have Medical Record Request form emailed, faxed, or mailed to you
   3. Pick up form in Main Lobby of SMMC

b) Complete *Medical Record Request Form* and send request to:
   1. Mail request to:

      Saint Michael Medical Center
      ATTN: Medical Records/ROI
      111 Central Avenue
      Newark NJ 07102
   2. Fax request to 973-877-5112
   3. Drop off completed form & **a copy of VALID PICTURE ID**

c) Options to obtain Medical Records

   Please remember to check an option in the box on the top right side of the form telling us how you would like to receive your medical records. Example:

   - ☐ Authorized person will pick up
   - ☐ Mail to Authorized person
   - ☐ Fax to Authorized person

1. If you choose - *Authorized person will pick up:*
   - ✓ The hours for medical record pick up are Mon-Fri 9am to 4pm
   - ✓ Location for pick up is Saint Michael's Medical Center's Main Lobby desk.
   - ✓ Authorized person must show valid picture I.D. (driver's license, passport)
   - ✓ Authorized person's I.D. must match the Authorized person listed on the Medical Record Request Form
   - ✓ Authorized person will sign Release Form provided by SMMC
2. If you choose – *Mail to Authorized person*
   - ✓ Please check to make sure the address is correct on the Medical Record Request Form.
3. If you choose – *Fax to Authorized person*
   - ✓ Please make sure the Fax number is correct on the Medical Record Request Form.

If you should have any further questions or problems, please contact the HIM Department at 973-877-5115.

Thank you for your understanding during this time.

HIM Manager