



MORRISTOWN CARDIOLOGY ASSOCIATES

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*Diplomates in Cardiovascular Disease  
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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](http://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 turn around time to complete medical records requests is 5 business days.
  - 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:

	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
	Lab Test Results: We will mail free of charge a lab report to a patient's primary care physician only. All other copies will be sent at a cost of \$1.00 each. Patient must provide name and address of physician.
	X-Ray Loan: \$50.00 refundable deposit
	X-Ray Copies: \$10.00 per sheet
	Echo Tape or CD Copy: \$50.00 per copy
	Nuclear Images Loan: \$100.00 refundable deposit
	Nuclear Images Copies: \$2.00 per page
	Nuclear Image copy requests received more than 10 business days after the study is performed will incur a \$25.00 re-processing charge

• 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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.  
182 South Street, Suite 5  
Morristown, NJ 07960



## 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 \_\_\_\_\_ Nuclear scan – dated \_\_\_\_\_

Doppler Study – dated \_\_\_\_\_ EKG – dated \_\_\_\_\_

Echocardiogram – dated \_\_\_\_\_ Holter Monitor – dated \_\_\_\_\_

Echo/Stress – 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

**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.