Senior Care

Family caring for family

MERRY HEART HEALTH CARE CENTER
200 Route 10 West, Succasunna, NJ 07876
Phone: (973) 584-4000 ext. 1421 Fax: (973) 440-1963

AUTHORIZATION FOR RELEASE OF INFORMATION

Resident ID No.: ____________

I do hereby consent to and authorize Merry Heart Health Care Center________________________to disclose to the person(s) named, information from my medical records
relating to my treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to the nursing home and to its employees for the release of information as specified below.

Purpose: ____ **Date:** ________________

Resident Name: ______________________________ **Phone:** ________________ **Date of Birth:** ______________

Treatment Dates Needed: ____

Specified Reports/Education Information: *(Check appropriate boxes)*

- ❑ Abstract: face sheet, history and physical, discharge summary, all medical tests, operative section
- ❑ All Medical Tests: labs, ECG, x-ray, operative section
- ❑ HIV/AIDS treatment records *(if our information contains HIV/AIDS related information you must check this box)*
- ❑ Drug/Alcohol treatment records
- ❑ Psychiatric treatment records
- ❑ Genetic
- ❑ Other: ____
- ❑ Complete copy
- ❑ Certified Records
- ❑ Clinic
- ❑ Radiology Films
- ❑ Discharge Instructions
- ❑ Medication Reconciliation

A fee for copying medical records will be invoiced to the resident or legally authorized representative in accordance with N.J.A.C § 8:43G-15.3(d)(1)(2)(i)-(ii), HIPAA Privacy Standard§ 164.524 (c) (4). When payment is received the records will be released. -- For continuing care purposes, there will not be a charge for records sent directly to a physician or facility. -- Processing time will vary due to the status of the record. Once the form is received, an invoice for the associated fee or status letter will be sent to the requestor's address. There is no charge for your record if it is faxed or mailed to a physician's office or health care facility; however you are charged for the following fees for personal copies:

- *$15 processing fee (one-time fee per request)*
- *$1 per page for the first 100 pages (fee per encounter)*
- *$0.50 per page for additional 200 pages (fee per encounter)*
- *mailing fee (e.g., Fedex, UPS, USPS)*
- *CD or Flash Drive*

If your request requires a fee, please send payment as soon as possible to the Medical Records Department. Upon receipt, the medical record copy will be available for pick up or mailed within 30 days. Mail this request form to the address listed above - Merry Heart Health Care Center for Succasunna residents and Merry Heart of Boonton Township for Boonton residents.

Released
To: Name: ____ Phone: __________________
Address: ____ Zip:__________________
Special Instructions: ____ To be: ❑ Pick up ❑ Mailed

Unless otherwise revoked by me, this Authorization is valid for 6 months from he date above. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this Authorization.
I understand that I may refuse to sign this Authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility for benefits. MHS/MHBT cannot guarantee that 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 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. I hereby, knowingly and voluntarily, authorize MHS/MHBT to use or disclose my health information in the manner described above.

________________________________ ____________ ________________
Resident Signature *Date* *Signature of Witness*

If individual is unable to sign this Authorization, please complete the information below:

________________________________ ____________ ____________ ________________
Signature of authorized Legal Representative (POA), Health Care Agent, or other authorized Personal Representative *Relationship* *Date* *Signature of Witness*

Completed by : ____ **Date:** __________________

NOTICE TO RECIPIENT OF INFORMATION

Each disclosure made with the resident's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules 42 C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.