Bergen Medical Alliance PA

MDPartners
ENGLEWOOD HOSPITAL AND MEDICAL CENTER

180 Engle Street Englewood, NJ 07631
Phone: 201-567-2050 Fax: 201-568-8936
Email Signed Form To: BMANurse1@Bergenmedical.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM BERGEN MEDICAL ALLIANCE TO PATIENT (SELF)

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE COPIES OF MY MEDICAL RECORDS TO MYSELF CONCERNING MY TREATMENT

Records requested: (check all that apply) Cost of copying record(s) is $1.00 per page for all pages above 5 and will need payment prior to releasing records. (Note: copied records will need to be picked up and cannot be mailed). Records will be emailed at no charge up to 10 pages.

☐ Last Diagnostic test or other specified test and date(s): _____
☐ Last visit encounter or other specified date(s): _____
☐ All visits for _____ (Date) to _____ (Date), including any diagnostic testing

Note: Lab results and clinical summaries of visit encounters are available on the Patient Portal for 24/7 access. If you do not have access to the Patient Portal, please ask us to activate your user name. Lab results will only be emailed one time while waiting for your Patient Portal Activation.

The patient is requesting and agrees to the following: _____
Patient Signature

☐ Please email my record(s) to the following email address: _____
I understand that I hold Bergen Medical Alliance harmless and not in violation of HIPAA regulations for use of an unsecured email delivery at my request.

☐ I authorize the following individual to act as my surrogate to discuss and pick-up my records:

_____ _____
Name Relationship to Patient

_____ _____
Date of Birth of Surrogate Last 4 digits of Surrogate SS#

This request is valid for one year from the date below. Please do not ask us to fax records as we are unable to comply with that request due to MD Partners Policy.

PATIENT NAME: _____ BIRTH DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

_____ DATE: _____
SIGNATURE OF PATIENT

_____ _____
WITNESS NAME WITNESS SIGNATURE