Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043
Phone: 856 – 524 – 7243

INTAKE PACKET -- MARCROFT

Thank you for choosing Marcroft Medical Associates, P.C. ("Marcroft") for your neurologic and/or psychiatric needs. We will strive to make your experience as convenient and efficient as possible.

The contents of this Intake Packet include:

1. Patient Registration
2. Insurance Authorization and Assignment
3. Acknowledgment Statement for Notice of Privacy Practices & Notice of Privacy Practices
4. Review of Policies
5. Consent to Treatment
6. Limits to Privacy, Privileged Communications, and Confidentiality
7. Consent for Release of Medication History
8. Authorization for Release of Information

Additionally, please provide copies of any **guardianship papers**, if applicable.

Thank you for reading over these documents and doing your best to complete them. If something is unclear to you, please flag that item and ask us. Completed paperwork can be returned to Marcroft in any one of the following ways:

- In person to the Marcroft Practice Manager or your Marcroft clinician
- By fax: 856-524-7365
- By email: info@marcroftmedical.org
- By mail: Marcroft Medical Associates, PC
  1000 White Horse Road, Suite 802
  Voorhees, NJ 08043

If you have any questions, please contact us at 856-524-7243. We look forward to serving you.

Be well,
Johanna Hernandez
Practice Manager
Marcroft Medical Associates, P.C.

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

PATIENT REGISTRATION (PAGE 1 OF 3)

PATIENT INFORMATION **TODAY'S DATE:** _____

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
DATE OF BIRTH:	SEX: MALE / FEMALE___	SOCIAL SECURITY NO:	MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED	
ADDRESS:				APT:
CITY:		STATE:	COUNTY:	ZIP:
HOME PHONE:		CELL PHONE:	WORK PHONE:	
EMAIL:		PREFERRED LANGUAGE		

PARENT/GUARDIAN INFORMATION (FOR THOSE UNDER THE AGE OF 18 OR THOSE WHO HAVE A LEGAL GUARDIAN)

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:		APT:
CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	WORK PHONE:
EMAIL:	RELATION TO PATIENT:	

***PLEASE PROVIDE A COPY OF GUARDIANSHIP PAPERS IF YOU ARE THE PATIENT'S LEGAL GUARDIAN.

EMERGENCY CONTACT (IF DIFFERENT FROM PARENT/GUARDIAN INFORMATION ABOVE)

LAST NAME:	FIRST NAME:	RELATION TO PATIENT:
HOME PHONE:	CELL PHONE:	WORK PHONE:

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

PATIENT REGISTRATION (PAGE 2 OF 3)

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:			
INSURANCE ADDRESS:			
CITY:	STATE:	ZIP:	PHONE NUMBER:
MEMBER ID#:		GROUP#	
SUBSCRIBER'S NAME:		SUBSCRIBER DATE OF BIRTH:	SUBSCRIBER SSN:
RELATION TO PATIENT:			
SECONDARY INSURANCE NAME:			
INSURANCE ADDRESS:			
CITY:	STATE:	ZIP:	PHONE NUMBER:
MEMBER ID#		GROUP#:	
SUBSCRIBER NAME:		SUBSCRIBER DATE OF BIRTH:	SUBSCRIBER SSN:
RELATION TO PATIENT:			

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

PATIENT REGISTRATION (PAGE 3 OF 3)

PRIMARY PHYSICIAN INFORMATION

PHYSICIAN NAME:		PRACTICE NAME:	
ADDRESS:			SUITE:
CITY:	STATE:	ZIP:	PHONE #:

REFERRING PHYSICIAN INFORMATION

☐ CHECK HERE IF SAME AS ABOVE

PHYSICIAN NAME:		PRACTICE NAME:	
ADDRESS:			SUITE:
CITY:	STATE:	ZIP:	PHONE #:

☐ IF YOUR INSURANCE REQUIRES A REFERRAL, DO YOU HAVE ONE?

REASON FOR VISIT

WHAT IS THE REASON FOR YOUR VISIT?

WHAT SERVICES ARE YOU SEEKING FROM MARCROFT? HOW CAN MARCROFT HELP YOU?

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

INSURANCE AUTHORIZATION AND ASSIGNMENT

Patient Name: _____

I hereby authorize and direct the above named individual's insurance carrier(s) including Medicare, Medicaid, private insurance and/or any other health/medical plan to issue payment check(s) directly to Marcroft Medical Associates, P.C. ("Marcroft") for medical services rendered to the above named individual regardless of the individual's insurance benefits, if any. I understand by signing below that I am responsible for any amount not covered by insurance. I understand that benefits quoted by the insurance company are unfortunately not a guarantee of payment and I will be asked to pay any charges not paid by the above named individual's insurance company. If payment is not made when due, I agree to pay all reasonable costs and expenses related to collection of any outstanding balances including but not limited to reasonable attorneys' fees.

I hereby authorize Marcroft to furnish and/or release any information necessary to insurance carriers concerning the above named individual's illness and treatments including: HIV status, history of drug or alcohol abuse, cognitive or mental health disorders in order to process the insurance claims acquired in the course of the above named individual's examination or treatment, to allow a photocopy of my signature to be used to process the insurance claim for the period of lifetime claims. I become fully financially responsible for any and all changes incurred in the course of treatment authorized.

As noted above, Marcroft will bill the above named individual's insurance company. If I disagree with any amount the insurance company pays or does not pay, I am responsible for the terms of that agreement. Likewise, the insurance contract is an agreement between the named insured and the insurance company and as the subscriber, I am responsible for the terms of that agreement.

I understand that Marcroft may not participate in the above named individual's health insurance plan. Consequently, I understand that any payment made by the above named individual's health plan for covered services provided by Marcroft may be directed to me and NOT Marcroft. When the above named individual's health plan issues a check directly to me in payment of the charges submitted to the above named individual's insurance plan by Marcroft for the services provided, I understand that these funds are provided to me for the purpose of paying Marcroft for services provided to the above named individual. I agree to make full payment of these funds to Marcroft within fifteen (15) days of the date I receive the funds from the above named individual's health plan.

_____

Signature of Patient (he/she must sign if own guardian) Date

_____

Printed Name of Parent (if minor) or Legal Guardian, in lieu of patient

_____

Signature of Parent (if minor) or Legal Guardian, in lieu of patient Date

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043
856 – 524 – 7243

ACKNOWLEDGMENT STATEMENT FOR NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI). Your PHI means health information, including your demographic information, collected from you and created or received by your health care provider, health plan, employer, or a health care clearinghouse. PHI relates to your past, present, and future physical and/or mental health condition(s) and identifies you or there is a reasonable basis to believe the information may identify you.

You have the right to review our Notice of Privacy Practices ("Notice") before signing this Acknowledgment Statement. As provided in our Notice, the terms of our Notice may change.

If we change our Notice, the revised notice will be:

1. Distributed at the first date of service;
2. Posted in public areas, including the Marcroft website; and
3. Mailed if the patient/legal representative contacts the Privacy Officer in writing to request a copy.

You have the right to request that we limit/restrict how protected health information (PHI) about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

You have the right to revoke any limitations/restrictions, in writing, except where we have already made disclosures in reliance on your prior acknowledgement.

If you wish for us to communicate about your treatment with anyone outside the limits set by this Notice of Privacy Practice, please ask for an Authorization for Release of Information form.

By signing this form, you acknowledge your receipt of our Notice of Privacy Practices relative to our use and disclosure of protected health information (PHI) about you as outlined in this Notice.

Patient's Name: _____ Date: _____

_____ Date: _____
Signature of Patient (he/she must sign if own guardian)

_____ Date: _____
Signature of Parent (if minor) or Legal Guardian, in lieu of patient

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043
856 – 524 – 7243

NOTICE OF PRIVACY PRACTICES

For any matters concerning this notice, please contact:
Joan Kavuru
Privacy Officer
856 – 348 – 1190
joan.kavuru@bancroft.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- In certain situations where access would cause harm, we may deny access. Likewise, in other situations, we may deny you access. In these cases we must provide you with a review of our decision denying access and explain what your rights are.
- You do not have a right of access to the following:
    - Psychotherapy notes – Psychotherapy notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your health record.
    - Information compiled in a reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - PHI that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") to the extent that giving you access would be prohibited by law.
    - Information that was obtained from someone other than a health care provider under a promised of confidentiality and the requested access would be reasonably likely to reveal the source of information.
    - Information that is copyright protected, such as certain raw data obtained from testing.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days. If we deny your request for correction, you can attach a statement of disagreement to your records.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with (name and address), a brief description of the information disclosed, and why. The first accounting in any 12 month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make, those made for national security or intelligence purposes under Section 164.512(k)(2) of the federal privacy regulations, and those made to correctional institutions or law enforcement officials under Section 164.512(k)(5) of the federal privacy regulations). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1 or you can register a complaint by calling our Compliance Line 24 hours a day, 7 days a week at 1 – 800 – 385 – 4652. Your anonymity will be protected and your confidentiality will not be compromised.
- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability
- If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of others

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: January 31, 2017.

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

REVIEW OF POLICIES

Nature of the Provider-Patient Relationship

During your evaluation and course of treatment at Marcroft, your provider will ask questions about your background, your life situation, and your current concerns and will work with you to develop a treatment plan that is appropriate for you. It is important that you provide your provider with the information requested in order for him/her to make the best decision about your care, and it is equally important that you and/or your legal guardian participate in your treatment to achieve the best possible outcome for you.

Medications

If you are started on medications at any time during your treatment, it is important that you take your medications as prescribed. Do not discontinue your medications without first consulting your provider. You should not increase or decrease the dosage of your medication without your provider making that change in your instructions / treatment plan. You should report any unusual, concerning, or persistent side effects to your provider as soon as possible. **So that you do not run out of medications, you should call Marcroft (856 – 524 – 7243) at least 72 hours before you are due to take your last pill and have no more refills. Please note that not all medications can be called in to your pharmacy.** There are some medications which we are required to give you on prescription paper which you must present to a pharmacist. For these prescriptions, you must come to the office to pick up the written prescription. Also, please note that there will be times when you will need to see your provider again before your prescription can be refilled.

Please note that some insurance companies require a prior authorization for certain medications. If no prior authorization is obtained before filling your prescription, your pharmacy may charge you the full cost of the medication(s). Since there are many insurance policies with many different requirements for medication prior authorizations, it is your responsibility to find out what those requirements are by calling your insurance company. We will be happy to complete whatever forms are needed in order to obtain a medication prior authorization for you.

Responsibilities

While in treatment, you will also have certain responsibilities for payment and for keeping your appointments. Please note our Appointment Cancellation and No-Show Appointments policy:

- **Appointment Cancellation**

  If you are unable to keep your appointment, please notify us at 856 – 524 – 7243 at least 72 hours in advance so that we may provide an appointment to another patient who may be waiting. If you are unable to reach the receptionist you may leave a message on our voice mail or with our answering service. **Cancelling within 24 hours of your scheduled appointment will result in a $100 late cancellation fee, which is not covered by your insurance.**
- **No-Show Appointments**

  You will be charged a fee of $100 for all no-show visits. You would be responsible for this fee as it is not covered by your insurance.
- Additionally, multiple missed appointments and/or cancellations may result in dismissal as a patient from Marcroft, in which case you would need to seek care elsewhere.

Contacting Marcroft

Phone calls are answered during regular clinic hours between 8:30 AM and 4:30 PM Monday through Friday, except major holidays. An answering services takes calls for Marcroft during all other hours. For emergency care outside regular clinic hours, you should go directly to the nearest emergency room.

Also note that communicating with your provider via email is not considered good medical practice nor is it a secure way to communicate; however, we do allow it in certain circumstances. Ultimately, the best way to reach your Marcroft provider is by calling us at 856 – 524 – 7243.

Marcroft Medical Associates, P.C.
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Voorhees, NJ 08043

Forms

Forms for FMLA or disability, for example, can be reviewed but may need 10 – 14 days to process and may require us to see you for an appointment. A fee of no less than $25.00 will be charged depending upon the requirements of documentation.

Your Rights

As a Marcroft patient you have the following rights:

- To be treated with dignity and respect.
- To receive information you can understand about your illness and planned treatments.
- To take part in making care decisions with you and your guardian (as applicable).
- To know the name of the provider and staff taking care of you.
- To receive care in a safe environment and to be free from any form of abuse or harassment.
- To have your health care information treated confidentially.
- To receive a timely reply to any concerns or complaints.
- To know and to ask your providers about the financial relationships they may have with drug, medical product and medical devices companies.
- To ask questions you may have and offer comments and feedback.

If you are not satisfied with your care, please let our Practice Manager know immediately. We wish to address your concerns promptly.

We understand that seeing a provider is not always easy. Thank you for making the decision to receive care and for choosing Marcroft. Your commitment will be honored here and you will be treated with dignity and respect.

I have read and understand the information above. I agree to my responsibilities and the terms outlined above. I have been given the opportunity to ask questions and have received answers to those questions.

Signature of Patient (he/she must sign if own guardian) Date

Printed Name of Parent (if minor) or Legal Guardian, in lieu of patient

Signature of Parent (if minor) or Legal Guardian, in lieu of patient Date

Marcroft Medical Associates, P.C.
PATIENT'S CONSENT TO TREATMENT.

As the Legal Guardian of: _____, Date of Birth: _____

I hereby voluntarily give consent to Marcroft Medical Associates, P.C. ("Marcroft"), to conduct any and all treatment services deemed by a licensed professional (doctor, advanced practice nurse, psychologist, therapist, and/or other healthcare provider), within the scope of their practice, at Marcroft, to be necessary to diagnose, measure and alleviate the psychological, social and/or physical conditions associated with the individual for whom I have guardianship (collectively, the "Treatments"). I understand that I have the right to discuss any forms of potential Treatments and possible ill effects with the staff of Marcroft and to refuse any one or all recommended Treatments. In the event any medication or procedure is prescribed, I understand that I am entitled to an explanation of the potential risks associated with such medication or procedure and that the Marcroft staff is obligated to discuss with me, and gain my specific informed consent, on all established plans before administering any such medications or procedures.

I realize that in connection with the Treatments furnished pursuant to this consent, written and computerized records will be kept about the patient to ascertain his or her progress. Such data will be kept confidential in accordance with applicable state and federal law and released only pursuant to my written authorization, unless otherwise required or authorized by applicable law.

I have read this form, or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it. My consent to treatment is noted by my signature below.

Legal Guardian (Sign) _____ Date _____

Legal Guardian (Print) _____ Telephone # _____

Witness _____

Licensed Independent Provider _____ Date _____

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

LIMITS TO PRIVACY, PRIVILEGED COMMUNICATIONS, AND CONFIDENTIALITY

Parent/Guardian of: _____, Date of Birth: _____

Listed below are exceptions to privacy, privileged communication, and confidentiality. Information the patient discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the patient or someone else;
- The patient needs to be involuntarily hospitalized due to the debilitating effects of a mental illness or substance abuse;
- The patient is required to undergo a court-ordered examination;
- The patient discloses information about abuse, neglect, or exploitation of a minor;
- The patient discloses information about abuse, neglect, or exploitation of an aged or disabled adult;
- The patient's mental or emotional condition is used as a legal defense;
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the patient against a mental health professional in which case the disclosure and release of information shall be limited to that action.

I hereby give my consent for service to be provided under these conditions.

Parent/Guardian (Sign) _____ Date_____

Parent/Guardian (Print) _____

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

CONSENT FOR RELEASE OF MEDICATION HISTORY

I, _____, hereby authorize Marcroft to receive from the

Sure Scripts database a list of medications for _____.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"), as may be amended from time to time. I understand that my authorization shall remain valid from the date of my signature, and shall not expire unless and until I withdraw my authorization in writing. I have been informed that I may revoke this authorization, except to the extent that action has been taken in reliance thereon, by written or oral communication. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in my provider's Notice of Privacy Practices. I have also been informed of my right to inspect the information to be released and that all information will be handled confidentially.

I certify that this form has been fully explained to me, and that I understand its contents.

_____ _____
Signature of Patient Date

_____ _____
Signature of Person Authorized in Lieu of Patient Date

_____ _____
Printed Name of Person Authorized in Lieu of Patient Date

_____ _____
Signature of Provider Date

_____ _____
Printed Name of Provider Date

Marcroft Medical Associates, P.C.
1000 White Horse Road, Suite 802
Voorhees, NJ 08043

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, DOB, _____, SS# _____,
hereby authorize Marcroft to release to and receive from:

Name: Bancroft

Address: 1255 Caldwell Road; Cherry Hill, NJ 08034

Phone Number: 856-616-6448 (Central Records) Fax: 856-616-1528 (Central Records)

I authorize the release of copies of my medical records including treatment for psychological, alcohol, and/or drug abuse. (*NOTE: this form cannot be used by Marcroft to (1) re-disclose drug and alcohol records originating from a Part 2 provider or (2) release psychotherapy notes.*) The specific information to be released is limited to (exact information being requested must be specified):

- ☑ Progress Notes
- ☑ Treatment Plan
- ☑ Psychosocial Assessment
- ☑ Medications
- ☑ Change in Condition
- ☑ Medical History
- ☑ Diagnosis
- ☑ Psychiatric Evaluation
- ☑ Summary of Treatment
- ☑ Discharge Summary
- ☑ Duration of Treatment
- ☑ Lab Report
- ☐ Other: _____

And pertains to my treatment on or about (check all that apply):

☒ Present and ongoing

☐ Specific Date: _____

☐ Service from _____ to _____

This information is needed for the following purpose (indicate the specific reason):

- ☐ Referral to _____
- ☐ Continuity of Care Network
- ☐ Continuity of Care/Case Management and Coordination
- ☐ Maintain Ongoing Insurance Coverage
- ☐ Payment and Related Purposes (i.e., verification of service delivered, medical necessity, reimbursement).
- ☒ Other: Transfer of care from Bancroft to Marcroft

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"), as may be amended from time to time. I understand that my authorization shall remain valid from the date of my signature, and shall not expire unless and until I withdraw my authorization in writing. I have been informed that I may revoke this authorization, except to the extent that action has been taken in reliance thereon, by written or oral communication. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in my provider's Notice of Privacy Practices. I have also been informed of my right to inspect the information to be released and that all information will be handled confidentially.

I certify that this form has been fully explained to me, and that I understand its contents. I understand that I am not required to sign this authorization and that my healthcare provider may not condition treatment on my signing of this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and, in that case, will no longer be protected by HIPAA. (*NOTE: verbal authorizations are not permitted and are invalid.*)

Signature of Patient: _____ Date _____

Signature of Person Authorized in Lieu of Patient: _____ Date _____

Relationship: _____

Witnessed by: _____ Date _____

Copy Offered: _____ Accepted _____ Declined _____

This Authorization is not valid unless all pertinent sections are completed.