Community Family Practice, PA

MEDICAL RELEASE FORM

THIS FORM AUTHORIZES COMMUNITY FAMILY PRACTICE TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION OF THE PATIENT FOR THE PURPOSE DESCRIBED BELOW.

PATIENT INFORMATION

Name: ______________________________

DOB: ______________________________

Address: ______________________________

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Primary contact number: _______________

Patient Rights: You have the right to revoke/stop this authorization at any time in writing. Exceptions to this are listed in our Notice of Privacy Practices. A revocation/termination does not apply to releases of information that took place before the written revocation/termination was received by this practice. Information disclosed as permitted by this authorization may be redisclosed by the recipient and no longer protected by federal or state law. You have the right to refuse to sign this authorization. You are not required to sign this authorization in order to receive treatment from this practice. You understand PHI to be released may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless it is excluded above.

TYPES OF INFORMATION TO BE DISCLOSED

☐ **STANDARD RELEASE**
Last 3 years of office notes, consult notes, labs, and diagnostic imaging reports

☐ **FINANCIAL/INSURANCE RECORDS**

☐ **PSYCHOTHERAPY NOTES**
*If psychotherapy notes are requested, no other boxes can be checked/other records can be requested with this form.

☐ **RECORDS FROM:** _______________ **TO** _____________

☐ **OTHER:** ______________________________

DO NOT INCLUDE:
☐ Mental Health Records
☐ Communicable Diseases (including HIV/AIDS)
☐ Alcohol/Drug Abuse Treatment

FORMAT/DELIVERY/PURPOSE

☐ Paper
☐ Pick Up ☐ Mail
*Copy fees may apply for printed records

☐ CD-ROM
☐ Pick Up ☐ Mail
☐ Fax: (f) ______________________
☐ Other: ______________________

Purpose for release of information:
☐ Personal/general release
☐ Transfer of care to another PCP
☐ Coordination of care with specialist
☐ Other: ______________________

RECORDS TO

Community Family Practice may disclose the requested information to the following persons or entities, or classes/categories of persons or entities for the purpose on this form.

Name: ______________________________
Phone: _______________ Fax: _______________
Mailing Address: ______________________________
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EXPIRATION

☐ One-time use/disclosure
☐ This release of information may be used until: _______
☐ Continual release of information (expires 12 months from signature date)

SIGNATURE: ______________________________
Patient or Personal Representative Signature

DATE: ______________________________