Commonwealth
PRIMARY CARE

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Medical Records Release Form

Please provide the following information that is needed to assist the provider in locating the patient's records:

Patient Name _____ Date of Birth _____ SSN _____

Address _____Maiden name_____

Phone: Home _____ Work _____ Cell _____

REQUEST AUTHORIZATION

(initial)	To provide copies of my records to Commonwealth Primary Care, LLC from: Name (*receiving person/party*): Fax #: Address: Phone #: *(required to verify Fax #)*
(initial)	To provide **copies** of my records checked below to: Name (*receiving person/party*): Fax #: Address: Phone #: *(required to verify Fax #)*
(initial)	To permit **review** of my records checked below by (person's name):

This authorization applies to records from the following date or dates of service: _____

PURPOSE OF DISCLOSURE

□ At the request of the individual (patient) □ Other:

DESCRIPTION OF INFORMATION TO BE RELEASED

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

□ Entire Medical record	□ Emergency Room Records
□ Financial Reports	□ History and Physical Reports
□ Radiology Reports	□ Discharge Summary Reports
□ Laboratory/Pathology Reports	□ Medication Records
□ EKG/ECG Reports	□ Other (Please Specify)

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. Commonwealth Primary Care, LLC providers shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here:**

_____ _____ _____

Patient or Legal Representative signature **Patient Name (PRINT)** **Today's date Time**

As Legal Representative, my relationship to the patient is: _____

The patient is unable to sign because:

NOTE: There may be fees for provision of any or all requested information. I understand that I will be responsible to pay Commonwealth Primary Care, LLC $0.50/page up to 50 pages and $0.25/ page thereafter, to photocopy and release my medical records. Under most circumstances, the law permits up to 30 days for record requests to be processed, however records for treatment purposes can be immediately faxed to the patient's healthcare provider when requested. Parties receiving records related to this consent may not redisclose without a separate written consent except from a provider where permitted by law.