COMMONWEALTH
PRIMARY CARE, INC.

Medical Records Release

DATE: _________________________

PATIENT'S NAME: ____

ADDRESS: ____

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DATE OF BIRTH: ____________________________

INFORMATION OR RECORDS TO BE RELEASED:

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I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED:

FROM: ____________________________ TO: ____

_________________________________ ____

_________________________________ ____

_________________________________ ____

I AUTHORIZE COMMONWEALTH PRIMARY CARE TO RELEASE/RECEIVE THE CONFIDENTIAL HEALTHCARE RECORDS OF THE ABOVE LISTED PATIENT. I UNDERSTAND THAT I MAY RESTRICT THE DISCLOSURE AT ANY TIME. IT IS UNDERSTOOD THAT THESE RECORDS CAN INCLUDE ANY AND/OR ALL RECORDS RELATING TO MEDICAL AND/OR MENTAL HEALTH CONDITIONS, DRUG/ALCOHOL DIAGNOSIS AND TREATMENT, HIV RELATED TREATMENT AND DIAGNOSIS. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY MY PHYSICIAN IN THE TREATMENT OF MY MEDICAL CONDITION.

I UNDERSTAND THAT I WILL BE RESPONSIBLE TO PAY COMMONWEALTH PRIMARY CARE $.50/PAGE UP TO 50 PAGES AND $.25/PAGE THEREAFTER, TO PHOTOCOPY AND RELEASE MY MEDICAL RECORDS.

PARTY AUTHORIZED TO RELEASE RECORDS ____

DATE ______________________________ WITNESS ___________________________________

THIS RELEASE EXPIRES ONE YEAR FROM DATE OF SIGNATURE. THIS INFORMATION WILL NOT BE RELEASED WITHOUT THE APPROPRIATE SIGNATURE. PARTIES RECEIVING RECORDS RELATED TO THIS CONSENT MAY NOT REDISCLOSE WITHOUT A SEPARATE WRITTEN CONSENT EXCEPT FROM A PROVIDER WHERE PERMITTED BY LAW.

Updated 8/2018