Commonwealth Pediatrics

Formerly Chippenham Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ do hereby authorize the release of my child or children's medical records

from: Commonwealth Pediatrics

Old Jahnke Road	Harbour Pointe	Westchester Commons
7023 Old Jahnke Road	6510 Harbour View Court	15400 WC Commons Way
Richmond, Va. 23225	Midlothian, Va. 23112	Midlothian, Va. 23113
P:804-320-1353 F:804-320-6636	P: 804-739-8166 F: 804-639-6614	P: 804-549-5405 F: 804-379-8162

The records are to be forwarded to the following:

_____
New Physicians name

_____
New Physicians address

_____
New Physicians phone number and/ or fax number

Patients Name: _____ DOB: _____

Patients Name: _____ DOB: _____

Patients Name: _____ DOB: _____

Mother's Name: _____ Father's Name: _____

Please Circle reason for transfer:

AGE Insurance Change Relocation For a better Location

Other (please explain) _____

Please Circle the type of records requested:

Immunizations Only All Records Office Notes (please specify dates) Basic Records (includes Immunization record, Vital History and Last Well Visit)

Please Circle how you would like to receive your records: Paper copy Electronic copy (USB thumb drive)

I understand that I have the right to access my medical records in accordance with the law and the policies of Commonwealth Pediatrics. I understand that Commonwealth Pediatrics will charge me for copies of my medical records, and I have been provided a fee schedule. I understand that Commonwealth Pediatrics has the right to deny me access to my records in certain circumstances in accordance with the law. If Commonwealth Pediatrics deny me access to my medical information, I understand it will provide me with the reasons for this denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional. I understand that if I choose to pick up my medical records I will be required to show proper identification before the records will be released.

Please note that information disclosed pursuant to this report is no longer under the control of Commonwealth Pediatrics and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature_____ Date: _____

Relationship to Patient: _____

Helping children return to the business of being kids

Commonwealth Pediatrics
Formerly Chippenham Pediatrics

Medical Records Fee Schedule

You have requested that Commonwealth Pediatrics release your medical information to a person or entity outside of Commonwealth Pediatrics or that you would like to have a copy of your medical records. In accordance with the law, Commonwealth Pediatrics may charge you a fee for this service.

If Basic records area chosen, there will be no charge. Basic Records contain Immunizations record, vital history and last Well child exam

For copies from paper or other hard copy generated from computerized or other electronic storage, Commonwealth Pediatrics charges
50 cents per page for the first 50 pages
25 cents per page for pages 51 +
Plus, all postage and shipping costs

For an electronic copy of your medical records on a USB thumb drive, there is a flat rate charge of $30.00. We require that the parent pick up the electronic copy at either one of our locations. You will have to provide proper ID and sign that you received the electronic records. Once you have signed them out the USB drive is no longer the responsibility of Commonwealth Pediatrics.

Please note that Commonwealth Pediatrics has up to two weeks to process your request for medical records.
If you have any questions regarding our fee schedule, please contact our Privacy Officer at: (804)-320-1353.

I understand and agree to the fees and policies explained above.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Phone Number: _____

Date: _____

Current Address: _____

_____

_____

For office use only:

Date: _____ CPAM initial: _____