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 Office
7023 Old Jahnke Road
Richmond, Virginia 23225
Ph: 804-320-1353/ Fax: 804-320-6636

Harbour Pointe Office
6510 Harbour View Court, Suite 100
Midlothian, Virginia 23112
Ph: 804-739-8166/ Fax: 804-639-6614

Westchester Commons
15400 WC Commons Way
Midlothian, Virginia 23113
Ph: 804-549-5405/ Fax: 804-379-8162

The records are to be forwarded to the following·

New Doctor's Name: _____

New Doctor's Address: _____

New Doctor's Phone Or Fax Numbers: _____

Patient's Name:_____ DOB: _____

Patient's Name:_____ DOB: _____

Patient's Name:_____ DOB: _____

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

Please check reason for transfer:
❑ Age ❑ Insurance Change ❑ Relocation ❑ For A Better Location ❑ Other (please explain)_____

Please check the type of records requested:
❑ Immunizations Only ❑ All Records ❑ Office Notes (please specify dates) _____
❑ Basic Records (includes Immunization record, Vita: History and Last Well Visit)

Please check 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 the 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 denies 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, healthcare professional. I understand 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 the information is close 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: _____

*****IF THE PATIENT IS OVER THE AGE OF 18, THEY WILL NEED TO SIGN THE RECORDS RELEASE*****

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 are 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 $25. 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: _____