Authorization For Release Of Medical Records

I,______________________________ do hereby authorize the release of my childhood children's medical records from Commonwealth Pediatrics.

The records are to be forwarded to the following, or I would like to pick them up at ❑ Jahnke Road, ❑ Harbour Pointe, or ❑ Westchester.

Released to: ❑ Self ❑ Relative Name ______________________________ ❑ Other Physician ______________________________

Address: ____

Phone/Fax Number: ____

Patient's Name:____ DOB: ____________________

Patient's Name:____ DOB: ____________________

Patient's Name:____ DOB: ____________________

Patient's Name:____ DOB: ____________________

Mother's Name: ______________________________ Father's Name: ______________________________

Release please check reason to transfer:

❑ Age ❑ Insurance Change ❑ Relocation ❑ For A Better Location ❑ Other ______________________________

Check the type of records requested: ❑ Immunizations Only ❑ All Records ❑ Office Notes (please specify dates).
❑ Records (includes immunization record, vital history, and last well visit)

Do NOT Include: ❑ Mental Health Records (Rx, Diagnosis, Etc.) ❑ Communicable Diseases,
❑ Alcohol/Drug Abuse/Treatment, ❑ Reproductive Health.

Please check how you would like to receive your records:
❑ Paper Copy ❑ Electronic Copy (USB thumb drive) ❑ Email______________________________

******I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third-party. I am willing to accept this risk. This practice is not responsible for privacy or security of your health information after it is sent to you or others listed on this form***

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 denies me access to my records, I understand I will be provided with the reason for this denial in writing, and describe whether I have right to review of the denial. Performed by a licensed healthcare physician. Professional. I understand if I choose to pick up my medical records, I will be required to show proper identification before the record records will be released.

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

Signature: ____ Date: ____________________

Relationship To Patient: ____

Medical Records Fee Schedule

You have requested that Commonwealth Pediatrics release your medical records 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 immunization record, vital history, and last well child exam.

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

An electronic copy of your medical records on a USB thumb drive, there is a flat rate charge of $6.50. We required that the USB be picked up at one of our locations. You will have to provide proper ID and sign that you received the electric electronic records. Once you have assigned them out, the USB drive is no longer the responsibility of Commonwealth Pediatrics.

There will be no charge for email records.

Please note that Commonwealth Pediatrics has up to 15 days 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.

Understand and agree to the fees and policies explained above.

Print name:____

Signature: ____

Relationship to Patient: ________________________________

Phone Number: ____________________ Date: ____________________

Current Address:______________________________________

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For office use only:

Date: ______________ CPAM Initial: ____________