



Community
Family
Practice, PA

INCOMING MEDICAL RECORDS RELEASE FORM

THIS FORM AUTHORIZES THE LISTED PROVIDER TO DISCLOSE CONFIDENTIAL HEALTH INFORMATION OF THE PATIENT LISTED BELOW TO COMMUNITY FAMILY PRACTICE.

PATIENT INFORMATION

Name: _____

DOB: _____

Address: _____

Primary contact number: _____

Patient Rights: You have the right to revoke/stop this authorization at any time in writing. Exceptions to this are listed in our Notice of Privacy Practices. A revocation/termination does not apply to releases of information that took place before the written revocation/termination was received by this practice. Information disclosed as permitted by this authorization may be redisclosed by the recipient and no longer protected by federal or state law. You have the right to refuse to sign this authorization. You are not required to sign this authorization in order to receive treatment from this practice. You understand PHI to be released may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless it is excluded above.

FORMAT/DELIVERY/PURPOSE

Paper CD-ROM

Mail to: Community Family Practice
260 Merrimon Ave, Ste 200
Asheville, NC 28801
Ph: 828-254-2444

Fax to: 828-254-0660

Other: _____

Purpose for release of information:

- Personal/general release
 Transfer of care to another PCP
 Coordination of care with specialist
 Other: _____

SIGNATURE: _____

Patient or Personal Representative Signature

TYPES OF INFORMATION TO BE DISCLOSED

STANDARD RELEASE

Last 3 years of office notes, consult notes, labs, and diagnostic imaging reports

FINANCIAL/INSURANCE RECORDS

PSYCHOTHERAPY NOTES

*If psychotherapy notes are requested, no other boxes can be checked/other records can be requested with this form.

RECORDS FROM: _____ TO _____

OTHER: _____

DO NOT INCLUDE:

- Mental Health Records
 Communicable Diseases (including HIV/AIDS)
 Alcohol/Drug Abuse Treatment

RECORDS COMING FROM

This practice may disclose the requested information to COMMUNITY FAMILY PRACTICE for the purpose on this form.

Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

EXPIRATION

One-time use/disclosure

This release of information may be used until: _____

Continual release of information (expires 12 months from signature date)

DATE: _____

