



Community
Family
Practice, PA

OUTGOING MEDICAL RECORDS RELEASE FORM

THIS FORM AUTHORIZES COMMUNITY FAMILY PRACTICE TO DISCLOSE CONFIDENTIAL HEALTH INFORMATION OF THE PATIENT FOR THE PURPOSE DESCRIBED BELOW.

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
 Pick Up Mail

*Copy fees may apply for printed records

- CD-ROM
 Pick Up Mail

- Fax: (f) _____
 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 GOING TO

Community Family Practice may disclose the requested information to the following persons or entities, or classes/categories of persons or entities 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: _____

