Authorization for Release of Medical Information

Authorization for use/or disclosure of Protected Health Information.

I hereby authorize Community Health and Dental Care *(name of sender)*

Address: 351 W. Schuylkill Road, Suite G-15A, Pottstown, PA 19465 Phone: 610-326-9460 Fax: 610-222-5006

To disclose to: _____ *(name of recipient)*

Address: _____ City: _____ State: _____ Zip _____

Telephone: _____ Fax: _____

Name of Patient: _____ DOB: _____

Check the box and initial to specify which type of information is to be disclosed:

o	Medical Information	_____Start Date	__ to End Date _____
o	X-Ray Results	_____Start Date	__ to End Date _____
o	Lab Results	_____Start Date	__ to End Date _____
o	Progress Notes	_____Start Date	__ to End Date _____
o	Consultation Reports	_____Start Date	__ to End Date _____
o	All Healthcare Information	_____ Start Date	__ to End Date _____

Specify the records to be disclosed

Yes No Initials	I authorize the release of my STD results, HIV/ AIDS testing, whether negative or Initials positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that l must give specific written permission before disclosure of these test results to anyone.
Yes No Initials	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here. _____.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorized Representative of Patient:
Signed: _____
Name: _____
Relationship to Patient: _____

CHDC Witness:
Signed: _____
Name: _____
Date: _____

Please return to:
Community Health and Dental Care, Inc.
351 W. Schuylkill Rd., Suite G-15A
Pottstown, PA 19465

Medical and Dental Patient Transfer Survey

1. Which location were you seen at? _____
2. How long have you been a patient of Community Health and Dental Care? _____
3. Were you a patient of Medical, Dental, or both? _____
4. Please circle one of the following reasons for transferring out of the practice:
    a. Moving
    b. Changing providers
    c. Insurance change: Do you want to be contacted to see if your new insurance is accepted by CHDC? Y or N
    d. Dissatisfied with the practice. Why? _____
    e. Dissatisfied with the providers. Why? _____
    f. Other _____
5. Please explain why you are leaving

    _____

    _____

    _____
6. Would you recommend CHDC to others? ___ Yes ___ No
7. Additional Comments?

    _____

    _____

    _____

Thank you for taking the time to assist us with improving our services. Please remember that your feedback is necessary to help keep Community Health and Dental Care the Patient Medical Home of your needs.