CHDC Your Health. Our Community.

ch-dc.org
610-326-9460

Authorization for Release of Medical Information- Transfer Out

Please allow up to 14 days for requests to be processed.

Authorization for use/or disclosure of Protected Health Information.

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

Address: 351 W Schuylkill Rd, Suite G-15A City: Pottstown State: PA Zip: 19465

Telephone: 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 to specify which type of information is to be disclosed

☐	Medical Information	From Start Date:		To End Date:	
☐	X-ray Results	From Start Date:		To End Date:	
☐	Lab Results	From Start Date:		To End Date:	
☐	Progress Notes	From Start Date:		To End Date:	
☐	Consultation Reports	From Start Date:		To End Date:	
☐	All Health Care Information	From Start Date:		To End Date:	

Specify the records to be disclosed (Please circle and initial below)

Yes or 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 I must give specific written permission before disclosure of these test results to anyone.
Yes or 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:

Name (please print): ______________________

Signature: ______________________

Relationship to Patient: ______________________

CHDC Witness:

Name (please print): ______________________

Signature: ______________________

Date: ______________________

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Medical and Dental Patient Transfer Survey

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

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 check 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? (Yes or No) ______________________________
   - ☐ d. Dissatisfied with the practice. Why? ______________________________
   - ☐ e. Dissatisfied with the providers. Why? ______________________________
   - ☐ f. Other: ______________________________
5. Please explain why you are leaving:

____

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6. Would you recommend CHDC to others? (Yes or No) ______________________________
7. Additional Comments?

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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.