Medical Record Request / Consent to Release Form

Recovery Centers of America asks that you complete this form to obtain copies of medical records. There is no charge for a letter confirming treatment completion/dates of treatment or to send records directly to a health care provider for coordination of care. For questions, please contact (484) 803-9669 or email rcamedicalrecordsrequests@recoverycoa.com

Patient's Name:	**Date of birth:**
Date(s) of service:	**Location (s):**

Consent to Release of Medical Records:

I,_____, hereby authorize/give consent to Recovery Centers of America at _____to release and disclose the following medical records:

- ☐ Admission Assessment
- ☐ Presence in Treatment
- ☐ Progress in Treatment
- ☐ Psychosocial History*
- ☐ Psychiatric Evaluation*
- ☐ Physician's H&P*
- ☐ Diagnosis/Prognosis*
- ☐ Lab and Ancillary Tests*
- ☐ Medications Administered During Treatment*
- ☐ Medications at Discharge*
- ☐ Continuing Care Plans*
- ☐ Discharge Summary*
- ☐ Complete medical record*
- ☐ Inpatient records
- ☐ Outpatient
- ☐ MAT
- ☐ Completion Letter
- ☐ Other _____

The documents marked with an asterisk (*) above may include HIV related information. I agree to the release of such HIV related information in the documents selected above. Yes ☐ No ☐ Initials _____

For the purpose(s) of:

- ☐ Treatment of a Medical Condition
- ☐ Substance Abuse Treatment
- ☐ Continuing Care Plans
- ☐ Billing/Finance
- ☐ Other _____

To the following person(s) where records will be sent (please include fax number or email):

Recipient's Name:		**Phone No:**
Street:	**City:**	**Zip:**

This Authorization/Consent expires in ninety (90) days or on_____/___/___, whichever is later. I understand that I have the right to rescind this consent at any time verbally or in writing except as to information already released in reliance upon this consent.

I acknowledge that the medical records disclosed pursuant to this Authorization/Consent may no longer be protected and could potentially be redisclosed. Such disclosure must be consistent with other State and Federal Laws, including 42 CFR Part 2 which prohibits the recipient from making any further disclosures without my specific written consent.

_____ _____

Signature of Patient or Authorized Representative Date

RCA may ask for identification or other confirmation of your identity before providing medical records. RCA will respond to patients' medical record requests within 30 days of receiving this form (21 days in Maryland). If RCA is unable to process the request in that time, it may extend the time for responding an additional 30 days by notifying you in writing.

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Internal Use only

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