

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; Fax (484) 588 4248 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:

- | | |
|---|--|
| <input type="checkbox"/> Admission Assessment | <input type="checkbox"/> Medications at Discharge* |
| <input type="checkbox"/> Presence in Treatment | <input type="checkbox"/> Continuing Care Plans* |
| <input type="checkbox"/> Progress in Treatment | <input type="checkbox"/> Discharge Summary* |
| <input type="checkbox"/> Psychosocial History* | <input type="checkbox"/> Complete medical record* |
| <input type="checkbox"/> Psychiatric Evaluation* | <input type="checkbox"/> Inpatient records |
| <input type="checkbox"/> Physician's H&P* | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> Diagnosis/Prognosis* | <input type="checkbox"/> MAT |
| <input type="checkbox"/> Lab and Ancillary Tests* | <input type="checkbox"/> Completion Letter |
| <input type="checkbox"/> Medications Administered During Treatment* | <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> Treatment of a Medical Condition | <input type="checkbox"/> Billing/Finance |
| <input type="checkbox"/> Substance Abuse Treatment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Continuing Care Plans | |

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

Internal Use only

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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