Commonwealth Pediatrics, P.S.C.

Consent to Access Medical Records/ Privacy
18 years & older

Patient's Name: ______________________________ DOB: _______/______/______

SS#: ________-_______-_________ Patient's Phone: (____) ______-_________

I give permission for the following to act on my behalf in authorizing, requesting and receiving any medical information deemed necessary for continuation of my medical care.

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

Medical Records/Privacy

At Commonwealth Pediatrics, we are committed to protecting the security and privacy of your medical and personal information. Medical records are the property of CWP, kept in a secure location, and are accessed only for purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for your continuing care. You are entitled to one free copy of your medical record with a signed written request. Additional copies are provided for a fee of $1.00 per page.

⇒ I understand that CWP may call my home & place of employment for healthcare reasons, appointment reminders, to resolve billing issues, and may mail informational postcards to my home address, as well billing information requested verbally by me.

⇒ I understand that CWP may leave messages on my answering machine regarding appointments and limited lab information.

⇒ I understand that CWP may use an email address provided by me to communicate appointment, billing issues, immunization certificates or other forms requested by me.

⇒ I authorize CWP to email or fax immunization certificates and/or school forms to my personal or work fax, or mail to my home.

⇒ I authorize CWP to discuss patient information with any persons present during the visit regardless of whether I am present.

⇒ I understand that if I send a picture of myself CWP may display it within the office.

I acknowledge that I have received Commonwealth Pediatrics' Notice of Privacy Practices and Consent to Treat information. I understand that I can edit any of the above items.

______________________________ ____________________

Patient Signature **Date**