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Germantown, MD 20874
240-489-1108
240-474-0068
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www.poncianocw.com

Medical Records Request and Release of Information Form

Client Information:

Full Name ______________________

Date of Birth ______________________

Address ______________________

Telephone number ______________________

Email address ______________________

Requestor Information (if different from client)

Full Name ______________________

Relationship to the client ______________________

Address ______________________

Phone number ______________________

email address ______________________

Records Requested:

Specific Dates of Service (if applicable

____

Type of Records Requested (check all that apply)

- ☐ Full Medical Record
- ☐ Treatment Summary
- ☐ Progress Notes
- ☐ Diagnostic Assessments

Other (please specify): ______________________

Purpose of Request:

☐ Continuation of Care

☐ Personal Use

☐ Legal Purposes

☐ Insurance

☐ Other (please specify): ___________________________

Delivery Method:

☐ Pick up in person (**Fees: $25 preparation fee + .20 per page)**

☐ Mail to address provided above (**Fees: $25 Preparation fee + $8 postage + .20 per page)**

☐ Access through the client portal (**Fee: $25 Preparation fee)**

☐ Faxed to another health care provider directly **(No fee)**

Recipient information

Recipient Name: ______________________

Recipient Address: ______________________

Recipient Phone Number: ______________________

Recipient Email Address: ______________________

Authorization and Release of Information

I hereby authorize Ponciano Counseling and Wellness to release the above-requested medical records to the individual or entity named below. I understand that this authorization is valid for one year from the date of signing and that I may revoke this authorization at any time by providing written notice to Ponciano Counseling and Wellness, except to the extent that action has already been taken in reliance on this authorization.

I acknowledge that the information disclosed may include sensitive information such as mental health records, substance abuse treatment records, HIV/AIDS status, and other health-related information. I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

______________________________ Client Signature

______________________ Date