Children's Clinic of Wyomissing
2240 Ridgewood Road, Suite 100
Wyomissing, PA 19610
(610) 376 8691 / Fax (610) 376 8745

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: Name: _____

Address: _____

City. State, Zip: _____

Telephone No.: _____

Fax No.: _____

- I kindly request a phone call at _____ to inform me if there is a fee for record transfer.

To release to: **Children's Clinic of Wyomissing**
2240 Ridgewood Road, Suite 100
Wyomissing, PA 19610
Telephone No. 610-376-8691

I am aware that the medical record may contain information relating to the treatment of mental health, drug and alcohol abuse, HIV testing and AIDS related information. I assume sole responsibility for specifying what, if any, information **I do not wish to be released** on the following space provided:

_____

I further understand that my records contain confidential and privileged information and that by consenting to release of my records, I am waiving this privilege, and I hereby relieve and hold harmless The Children's Clinic of Wyomissing from any liability related to the release of my records. I also understand that I have the right to revoke this authorization at any time otherwise this medical record release is in full force for **60 days from the above date**.

____ **I request that only vital (**Immunizations, last physical exam, growth chart, latest lab, positive x-rays, positive labs and allergies, letters from consultants, hospitalizations, office visits for chronic problems, newborn summaries, records from previous physicians**) information are to be copied**

____ **I request copy of my full chart.**

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PLEASE SPECIFY REASON FOR REQUEST:_____

- _____ Date _____
  Signature of Patient or Guardian if Patient is a minor (under age of 18)

02/22/18