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 From CCW

I hereby authorize: Name: **Children's Clinic of Wyomissing**
Address: 2240 Ridgewood Road, Suite 100
Wyomissing, PA 19610
Telephone No.: 610-376-8691

To release to: Name _____

Address _____

City, State, Zip: _____

Telephone No. _____

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**.

The Fee for copies is as follows:

Pages 1 to 20 $1.39 **per page**
Pages 21 to 60 $1.03 **per page**
Pages 61 + $0.34 **per page**
Plus mailing cost

CHILDREN'S CLINIC OF WYOMISSING WILL NOT FAX PATIENT RECORDS

Payment is due at time of record retrieval from Children's Clinic. It is understood that once the request is made and completed all charges are payable. If the record is not retrieved copy charges are applied to patient account.

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

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

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____

PHONE:_____

PLEASE SPECIFY REASON FOR REQUEST:_____

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

December 19, 2011