



**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  
  Fax No.                        610-376-8745

To release to:               Name \_\_\_\_\_  
  Address \_\_\_\_\_  
  \_\_\_\_\_  
  Telephone No. \_\_\_\_\_  
  Fax 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   \$1.32 **per page**  
Pages 21 to 60   \$0.98 **per page**  
Pages 61 +   \$0.33 **per page**  
Plus mailing cost.

***I understand that once I make my request all copy charges are applied to my account and are payable within 15 days.***

\_\_\_\_\_ **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: \_\_\_\_\_

**PLEASE SPECIFY REASON FOR REQUEST:** \_\_\_\_\_

• \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Guardian if Patient is a minor (under age of 18)