All About Children Pediatric Partners, PC

655 Walnut Street, West Reading, PA 19611
Mailing Address: PO Box 6946, Reading, PA 19610-6946
Telephone: 610-372-9222 FAX: 610-372-0232 Website: www.aacpp.com

Request for Medical Records

TO: Facility (Pt. number if applicable) Address Phone/Fax#

Hospital where your child was born: _____.

Last Dr./Clinic where your child was seen: _____.

Inpatient Hospitalization(s) _____.

Emergency Room(s) _____.

Any other Doctors or Specialists who saw your child _____.

_____.

To support ongoing care of this patient, please forward copies of the health records of

_____.

Name Birthdate Social Security #

to include the following

Medical records:	Laboratory & x-ray reports	HIV testing and related information
Inpatient	Drug and alcohol information	Immunizations
Outpatient	Social work evaluations	Psychological &/or Educational evaluation/testing
Newborn	Records in your possession from previous providers of care	

Mail to: All About Children Pediatric Partners, PC
P.O. Box 6946, Reading, PA 19610-6946

Fax to: 610-372-0232
Direct address: Eve.kimball@direct.meditouchehr.com

- This information, which may include sensitive psychiatric/substance abuse/HIV/AIDS, and mental health information, is needed for the purpose of continuity of medical care.
- I understand this information is disclosed from records whose confidentiality is protected by State and Federal Privacy Regulations.
- I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment. However, I understand that better health care can be provided by AACPP if they are able to obtain these records. I further understand that authorization is necessary to take part in any research study or to receive health care when the purpose is to create health care information for a third party
- AACPP will protect these records to the best of their ability.
- These records may be conveyed from the above sources to AACPP by fax or US Mail.
- I also understand that I may revoke this authorization (except to the extent that action has already been taken) at any time by written, dated communication to any agency involved.
- This authorization is effective for a period of one (1) year from the date of my signature or until the requested agency has complied with this request.
- The nature of and purpose for this release have been explained to my understanding.
- I acknowledge that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

_____.
Signature of Patient/Parent/Guardian Date

_____.
Signature & Identity of Witness Date

Sent / Faxed on _____ by _____