

# All About Children Pediatric Partners, PC

301 Penn Ave. Suite 200, Reading, PA 19611

132 S. 5th Street, Reading, PA 19602

Mailing Address: PO Box 6946, Reading, PA 19610-6946

Telephone: 610-372-9222

## Authorization to Release Confidential Information

**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 (Unless crossed out):		
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
	Records in your possession from previous providers of care	

**Mail to: All About Children Pediatric Partners, PC** **Fax to: 610-372-6188**  
**P.O. Box 6946, Reading, PA 19610-6946** **610-372-0232**

- 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.

Signature of Patient/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature & Identity of Witness \_\_\_\_\_ Date \_\_\_\_\_

Sent / Faxed on \_\_\_\_\_ by \_\_\_\_\_