All About Children Pediatric Partners, PC

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

Authorization to Release Confidential Information

TO: All About Children Pediatric Partners, PC

Please forward copies of the health records of

Name:_____ Birthdate:_____ SSN: _____.

including the following: (Unless crossed out)

Medical records:
- Inpatient
- Outpatient

Records from previous providers of care

Laboratory & x-ray reports
Drug and alcohol information
Social work evaluations

HIV testing and related information
Immunizations
Psychological and/or
Educational evaluation/testing

To: _____.

Address: _____ Fax : _____.

_____.

_____.

- 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 AACPP to the provider listed above 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

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_____.
Signature & Identity of Witness Date

Sent / Faxed on_____by_____.