

Penn State Medical Group- All About Children

655 Walnut Street, West Reading, PA 19611 Telephone: 610-372-9222 Fax: 610-372-0232

Request for Medical Records

TO: **Facility (Pt. number if applicable)** **Phone/Fax#** **Date of Service**

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 #
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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 (including metabolic/genetic screening)		Records in your possession from previous providers of care

Mail to: Penn State Health Medical Group- All About Children **Fax to:** 610-372-0232
655 Walnut Street, West Reading, PA 19611

- 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 PSHMG-AAC 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
- PSMG-AAC 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 _____

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