40 Berkshire Court, Suite 1, Wyomissing, PA 19610
Phone: 610-374-7400 Fax: 610-374-4252

Authorization for release, use and disclosure of Protected Health Information (Please print):

Last name _____ First name _____ Date of Birth _____

Address _____ Phone _____

I Authorize: _____ Facility

Release To: _____ Facility

Address _____

Phone _____ Fax _____

Address _____

Phone _____ Fax _____

Dates information is to be released: From _____ Through _____.. (check all that apply below)

___ Complete Records ___ Discharge Summary Labs Outpatient Notes

___ Radiology/Imaging ___ Speech and Hearing ___ PT/OT Notes ___ Emergency/Trauma

___ Copy to Parent Medication list ___ Operative EKG's

Other: _____

New Patients Only – Please list current insurance plans:

Primary Insurance/ID Number: _____ Subscriber Name/DOB: _____

Secondary Insurance/ID Number: _____ Subscriber Name/DOB: _____

_____ **If we are obtaining medical records from your previous physician, please check here.**
(PREVIOUS PHYSICIAN: PLEASE NOTE THAT WE DO NOT ACCEPT FAXED MEDICAL RECORDS)

Reason for disclosure of medical records (check all that apply below)

___ Legal Investigation/Action ___Moving Out of Area __ Further Medical Care ___ Specialist being seen

___ Age ___ Insurance Change __ Personal __ Transfer of Care __ Asked to Leave

** If transferring to another provider, reason for leaving: _____

All medical records are copied to a "flash drive". When completed, the "flash drive" can be picked up in our Wyomissing office or be mailed to the address you specify above. The charges for medical records are as follows:

Paper copies of medical records **must be picked up** in the Wyomissing office, they cannot be mailed.

I WOULD LIKE TO RECEIVE THE INFORMATION REQUESTED VIA: (please check one)

( ) Pick up flash drive $20.00 ( ) Mail flash drive $25.00 ( ) Pick up paper $40.00

(SEE BACK FOR SIGNATURES)

I understand the following:

- I may revoke authorization in writing at any time; this revocation will not apply to information that has already been released in response to this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by the recipient and will no longer be protected under the terms of this authorization.
- I have the right to inspect or copy the health information to be used or disclosed as permitted by law.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits (if applicable).
- Reading Pediatrics may receive compensation for medical records by copying them in accordance with PA law, 42 Pa.C.S. 6152.

I understand that this consent will expire 90 days from the date below, or upon my death, whichever occurs first.

Guardian, Parent or Patient-18 years or older signature _____ Date _____

Printed Name _____ Relationship to Patient _____

I authorize the release of psychiatric/psychotherapy records, mental health records, and drug and alcohol information or treatment records under the same terms and conditions.

Guardian, Parent or Patient-14 years or older signature _____ Date _____

Printed Name _____ Relationship to Patient _____

Witness _____ Date _____

Important information that you should know:

Our mailing address is: Reading Pediatrics, Inc.
Attn: Medical Records
40 Berkshire Court, Suite 1
Wyomissing, PA 19610

- Records are to be picked up in the Wyomissing office only. Pick up hours are 8:00AM - 7:00PM
- Complete records will not be faxed
- Please be prepared to show ID
- When picking up records for a patient that is over the age of 18 years, a medical Power of Attorney documentation or Legal Guardianship document is required if patient is not present.
- When applicable our compensation for copying records in accordance with Pennsylvania Law, 42 Pa.C.S. 6152, 6152.1 and 6155