Children's Clinic of Wyomissing
2240 Ridgewood Road, Suite 100
Wyomissing, PA 19610
(610) 376 8691 / Fax (610) 376 8745

REQUEST FOR RELEASE OF MEDICAL INFORMATION From CCW

I hereby authorize: Name **Children's Clinic of Wyomissing**
Address 2240 Ridgewood Road, Suite 100
Wyomissing, PA 19610
Telephone No. 610-376-8691

To release to: Name ____

Address ____

City, State, Zip____

Telephone No. ____

Fax No. ____

I am aware that the medical record may contain information relating to the treatment of mental health, drug and alcohol abuse, HIV testing and AIDS related information. I assume sole responsibility for specifying what, if any, information **I do not wish to be released** on the following space provided:

____

I further understand that my records contain confidential and privileged information and that by consenting to release of my records, I am waiving this privilege, and I hereby relieve and hold harmless The Children's Clinic of Wyomissing from any liability related to the release of my records. I also understand that I have the right to revoke this authorization at any time otherwise this medical record release is in full force for
60 days from the above date.

The Fee for copies is as follows:

Pages 1 to 20 $1.42 per page
Pages 21 to 60 $1.05 per page
Pages 61 + $0.34 per page
Plus mailing cost (All records are mailed CERTIFIED MAIL which is $5.65 plus weight charge)
CHILDREN'S CLINIC OF WYOMISSING WILL NOT FAX PATIENT RECORDS and we recommend that the chart copy be picked up from our office to avoid mailing cost

It is understood that once the request is made and completed all charges are payable even if the chart is not retrieved from the office. Non-retrieved copies will be destroyed after 6 months.

____ **I request that only vital information documents** (Immunizations, last physical exam, growth chart, latest lab, positive x-rays, positive labs and allergies, letters from consultants, hospitalizations, office visits for chronic problems, newborn summaries, records from previous physicians) **be copied.**
____ **I request copy of my full chart.**

PATIENT NAME: ______________________________ BIRTHDATE: ________________

ADDRESS: ____

PHONE:____

PLEASE SPECIFY REASON FOR REQUEST:____________________________________

- ____ Date ______________
  Signature of Patient or Guardian if Patient is a minor (under age of 18)

January 4, 2013