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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I_____ hereby request a copy of my health records and authorize Reading Pediatric Associates PC to disclose a copy of my health records to me.

(Note: In order to protect your health information, we will ask you for an ID before releasing your charts.)

I want my records: ☐ Sent Through Web Portal (Pdf File) ☐ Copied on Paper

NAME OF ALL PATIENTS AND DATES OF BIRTH:

_____

_____

RELEASE MY MEDICAL RECORDS TO:

NAME OF PARENT OR PATIENT: _____ CELL: _____

ADDRESS: _____

REASON FOR REQUEST: _____

☐ Record Request for ALL dates **OR** ☐ Record Request for treatment dates _____ to _____

I authorize Reading Pediatric Associates, PC to disclose the protected health information described below:

☐ I authorize the release of my **full** health record. If applicable, this would include records relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse..

OR

☐ I authorize the release of my complete health record **with the exception** of the following information:

Mental Health Records
Communicable diseases (including HIV and AIDS)
Alcohol/Drug Abuse treatment
Pregnancy/ Sexual Activity
Other (please specify):

IF OVER 18: I give my parents permission to pick up my records Yes No

Please note: Medical records cannot be copied upon demand. The normal completion time is 3 to 5 days.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

FOR RECORDS COPIED ON PAPER AND PICKED UP FROM OFFICE: INCLUDE A $10 FEE PER RECORD
FOR RECORDS COPIED ON PAPER AND MAILED: INCLUDE A $25 FEE PER RECORD
THERE IS NO CHARGE FOR RECORDS SENT THROUGH WEB PORTAL

($60 MAXIMUM PER FAMILY)