Penn State Health Medical Group- All About Children

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

Authorization to Release Confidential Patient Information

TO: Penn State Health Medical Group- All About Children

Please forward copies of the health records of

Name:_____ Birthdate:_____ SSN: _____.

Including all of the following: (**Unless crossed out**)

Inpatient Medical Records Laboratory & x-ray reports HIV testing and related information
Outpatient Medical Records Immunizations Psychological/Educational evaluation/testing
Records from previous providers of care Drug and alcohol Mental/Behavioral Health Records

To: _____. **Secure Email:** _____

Address: _____. _____

_____.

_____. **Fax :** _____.

- ☐ **Records will be released AFTER we receive confirmation that you have changed your PCP with your insurance.**
- ☐ 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.
- ☐ PSHMG-AAC will protect these records to the best of their ability.
- ☐ These records may be conveyed from PSHMG-AAC to the provider listed above by HIPAA compliant email, 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 disclosure by the recipient.

Transfer of records requested because _____.

_____. _____.

Signature of Patient/Parent/Guardian Date Signature & Identity of Witness Date

_____.

Signature of Patient ≥ 14 years old Date

(*Only if Behavioral Health, Drug and Alcohol Treatment, and Reproductive Health records are released.)*

_____.

New address and phone number of family

Sent / Faxed / CD to parent on_____by_____.