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

REQUEST TO TRANSFER MEDICAL RECORD

I hereby authorize: **Children's Clinic of Wyomissing**
2240 Ridgewood Road, Suite 100
Wyomissing, PA 19610
610-378-1722

To transfer copy of records to:

Name _____

Address _____

Telephone 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**.

CHILDREN'S CLINIC OF WYOMISSING WILL NOT FAX PATIENT RECORDS and we recommend that USB Flash Drives be picked up from our office to avoid mailing cost

Fee for copies is as follows:

$30.00 ($30.00 per each Complete chart on USB Flash Drive plus CERTIFIED, Return Receipt mailing cost.)
Patients covered under Medical Assistance are exempt from the charge.

The Fee is payable at time of request. For your convenience, the following forms of payment are accepted; Cash, Personal Check, Visa, Master Card, American Express and Discover.

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____

PHONE No. :_____

PLEASE SPECIFY REASON FOR REQUEST: _____

PLEASE NOTE - Once the request is completed by our office you are no longer a patient in this practice and it's your responsibility to establish care with physician of your choice.

- _____ Date _____
  Printed name & Signature of Patient or Guardian if Patient is a minor (under age of 18.)
  All patients over the age of 18 must personally sign the request)

- If someone other than yourself will pick up records, please list authorized people otherwise the USB Flash Drive will not be released:_____