Lehigh Valley Peds

Lehigh Valley Pediatric Associates, Inc.
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Date:_____

REQUEST FOR MEDICAL RECORDS

Name of Patient(s): Date of Birth(s):

_____ _____

_____ _____

_____ _____

Release information from: **Lehigh Valley Pediatric Assoc., Inc.**

PROVIDE EMAIL ADDRESS for Receipt of Encrypted Medical Records _____

*****MEDICAL RECORDS WILL BE RELEASED TO PATIENT OR PARENT/GUARDIAN OF MINOR CHILD(REN)***

Name and address of patient or parent/guardian of minor child(ren) requesting records:

_____

_____

_____

Type of Medical Records requested: ❑ All records ❑ Specific information (note below)

_____

I understand and authorize the release of this information which may contain information protected by: Confidentiality of HIV-Related Information Act (AIDS, HIV-related information or testing), Mental Health Procedures Act (Psychiatric disorders), Drug and Alcohol Abuse Control Act (Drug and/or Alcohol treatment).

Signature of patient or parent/guardian of minor child(ren):_____

Relationship to patient(s): _____ Phone #_____

❑ **Transferring to another physician's office - Name of Physician:** _____

Reason for transfer (be specific): _____

_____

❑ **Copy of Medical Records for Personal Use Only**

— THIS PORTION FOR OFFICE USE ONLY—

Secure Email _____ Paper _____ **Cost for Medical Records**_____

Insurance: _____ Account Balance: _____

Approval Signature: _____ Date: _____

Notes:_____

_____

_____

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