PEDIATRICS of Northeastern Pennsylvania

Reason for request: _____ Transfer Medical Records _____ other

This request may include disclosure of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH INFORMATION and CONFIDENTIAL HIV-RELATED INFORMATION only if Patient's / Legal Guardian's initials are included next to the desired information below.

Initial for release of: _____Alcohol/Drug Treatment _____Mental Health Information _____HIV-Related Information

Patient name (s): _____ Date (s) of birth: _____

_____ _____

Patient Address: _____

Patient's Primary contact number: _____

My child/children's records are to be transferred to/from:

Physician Name: _____

Address: _____

Phone: _____Fax # _____

Reason for Transfer: _____

We recommend a summary medical record to be created which includes: growth charts, immunization, allergies, current medication list, labs, x-rays, specialist reports of last 24 months, problem list and diagnosis summary list. We have 3options for obtaining your records: **Processing time for both options is 5-7 business days. Payment can be made via phone. Please circle choice below:**

Paper chart **CD** **Fax**

Please note: copies of a complete records are available upon request subject to processing fees. Processing fee will be calculated based on copying rates set by the federal government.)

_____ _____

Signature of Patient/Legal Guardian Date

_____ Records will be picked up: ____Yes _____ No

Printed Name of Patient/Legal Guardian

Name/phone number of person to pick up records: _____

To be signed at pick up: Printed

Name: _____Signature: _____Date: _____

Peds of NEPA
920 Viewmont Drive
Dickson City, PA 18519
570-346-1464 fax- 570-558-9051
www.pedsofnepa.com