



220 NORTH 5TH STREET
READING, PA 19601
(610) 372-7960
(610) 372-8807 FAX

2454 BRODHEAD ROAD
BETHLEHEM, PA 18017
(610) 997-0123
FAX (610) 997-7611

Date: _____

Name: _____

Address: _____

I am requesting the following information from my medical record be released to me/myself and mailed to the address listed above:

Please list specific documents that you wish to be sent:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

Please include the reason for the request:

Client signature

date