

PEDIATRIC ASSOCIATES OF WESTERN CONNECTICUT

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AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

PATIENT INFORMATION:

DATE:	DOB:
PATIENTS NAME (PLEASE PRINT):	
STREET ADDRESS:	
CITY/STATE/ZIP CODE:	PHONE NUMBER:

RELEASE MEDICAL RECORDS TO:
ADDRESS OF RECIPIENT:
CITY/STATE/ZIP CODE:

MAIL(Out of State Only) **PICK UP**

INFORMATION REQUEST:

- ALL MEDICAL RECORDS
- RECORDS PERTAINING TO SPECIFIC DATE OF SERVICE: From _____ To _____
- IMMUNIZATION RECORDS
- OTHER: _____

REASON FOR TRANSFER:

- RELOCATION
- CHANGE OF INSURANCE: _____
- DISSATISFACTION OFFICE OR MEDICAL CARE
- OTHER: (PLEASE SPECIFY) _____

SIGNATURE: _____ **DATE:** _____

(of patient or legal guardian, if patient is a minor. Patients 18 years and older must sign for themselves).

HIGHLY CONFIDENTIAL INFORMATION:

SIGNATURE: _____ **DATE:** _____

By signing my name I authorize the release of all highly confidential information including Mental Illness or Developmental Disability, HIV/AIDS test results and Substance (drug or alcohol) Abuse.

AUTHORIZATION IS VALID FOR ONE YEAR, UNLESS REVOKED BY THE PATIENT.