Center for Pediatric Medicine
Our Family Caring For Yours

107 Newtown Road, Suite 1D
Danbury, CT 06810
203-790-0822
Fax: 203-790-1808

Authorization for Release / Request of Health Information

Date_____ ☐ **Transferring In** ☐ **Transferring Out**

Patient name: _____ **DOB:** _____ **Phone #**_____

Address _____ **City**_____**State**_____**Zip:** _____

Additional Children for transfer:

1)_____**DOB:** _____ **2)**_____**DOB:**_____

3)_____**DOB:** _____ **4)**_____**DOB:**_____

Release records from: _____ **phone number** (_____)_____

Address _____ **City**_____**State**_____**Zip:** _____

Release records to: _____ **phone number** (_____)_____

Address _____ **City**_____**State**_____**Zip:** _____

***Please note only charged if you are transferring out of The Center for Pediatric Medicine**

☐ I authorize Center for Pediatric Medicine to copy my records at the cost of $.45 per page maximum $40.00 per chart

☐ I authorize Center for Pediatric Medicine to copy my records electronically onto a USB flash drive at the cost of $10 for pick up or $15 for mail.

Mail to: _____ **Pick up**_____

Specific Information requested: Whole Chart____ Immunization/Growth Chart/Last PE _____ Other: _____

Reason for Transfer

☐ We're Moving ☐ Aged out

☐ Leaving the practice if so why: _____

☐ Need them for a specialist _____ (not leaving the practice)

☐ Need them for insurance or legal matter _____ (not leaving the practice)

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)

Patient's Signature_____ Date _____

* *

Patient is a minor, or patient is legally unable to sign

_____ Date_____

Please contact our Business Office at 798-7661 to settle any open balances prior to transfer of medical record*

Please Note: CT law allows 30 days for transfer of the medical record.

(Print Name)

_____ _____

(Signature of Authorized Person) (Relationship to Patient)

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