



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

(Print Name) 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.



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(Signature of Authorized Person)

(Relationship to Patient)

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