



Center for Pediatric Medicine

Our Family Caring For Yours

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

83 Sandpit Road
Danbury, CT 06810
203-746-3280

11 Route 37
New Fairfield, CT 06812
203-791-9599

We do NOT fax Medical Records

Authorization for Release / Request for Health Information - Transfer Out Release

☐ Transferring Out

Date _____

Patient name: _____ DOB: _____ Phone # _____

Address _____ City _____ State _____ Zip _____

☐ MAIL (Out of State Only) ☐ PICK UP

Release records from: Center for Pediatric Medicine - 107 Newtown Road Suite 1D Danbury, CT 06810

Release records to: _____ Phone # _____

Address _____ City _____ State _____ Zip _____

☐ I authorize the Center for Pediatric Medicine to copy my records at the cost of **\$20 up to 50 pages maximum. 51 pages or more** will be put on **USB Flash Drive**. If you would like the paper copies mailed (out of state only to a home address - we do NOT mail to a providers office due to records being misplaced), we will charge postage to mail in addition to the **\$20 fee for paper copies**. **

All records must be pre-paid prior to releasing them.

☐ I authorize Center for Pediatric Medicine to copy my records electronically onto a **USB Flash Drive at the cost of \$10 for pickup**.

** If you would like the USB Flash Drive mailed (out of state only to a home address - we do NOT mail to a providers office due to records being misplaced), we will charge postage to mail in addition to the **\$10 USB Flash Drive cost**. **

All records must be pre-paid prior to releasing them.

Mail to Home Address Only _____

City: _____ State: _____ Zip Code: _____

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 matters _____ (not leaving the practice)

Signature _____ Date _____

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

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)

(Print Name)

(Date)

AUTHORIZATION IS VALID FOR ONE YEAR

****Please contact our Business Office at (203) 798-7661 to settle any open balances prior to transfer of medical records****

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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