Pediatric Associates, LLC

Your medical records cannot be released until this form is completed. This form must be signed by the patient or his/her legal guardian (if a minor) and returned to Pediatric Associates, LLC. 43 Enterprise Dr. Bristol, CT 06010. MEDICAL RECORDS WILL ONLY BE FAXED FOR MEDICAL EMERGENCY REASONS. IT IS OUR RESPONSIBILITY TO KEEP YOUR RECORDS SECURE AND PRIVATE.

Please print on this form and check for accuracy.

PATIENT INFORMATION *(PLEASE PRINT)*:

FIRST NAME_____**MIDDLE** _____ **LAST NAME** _____

ADDRESS _____**DATE OF BIRTH**_____

CITY/STATE/ZIP _____ **PHONE** _____

WHO HAS THE RECORDS NOW:

PHYSICIAN'S NAME_____***, M.D.***

PHYSICIAN'S ADDRESS_____***PHONE***_____

CITY/STATE/ZIP _____

TO WHOM THE RECORDS WILL BE RELEASED TO:
TRANSFER OF CARE: O YES O NO

RELEASE TO (PHYSICIAN'S NAME) _____***, M.D.***

PHYSICIAN'S ADDRESS _____ ***PHONE***_____

CITY/STATE/ZIP_____

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE SIGNED AND MAY BE REVOKED IN WRITING AT ANY TIME.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN (IF MINOR) ***DATE***

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, VENEREAL DISEASE, HEPATITIS TESTING/TREATMENT, PSYCHIATRIC AND OR OTHER SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN (IF MINOR) ***DATE***

IF YOUR WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS TO BE RELEASED PLEASE SIGN BELOW:

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN (IF MINOR) ***DATE***