Authorization for Release of Medical Records TO Pediatric Associates of Conn., P.C

I authorize the following health information to be released from the record of:

______________________________ Patient Name

________________________ Date of Birth

____________________ Phone Number

Release records TO:

Pediatric Associates of Conn PC
160 Robbins Street
Waterbury, CT 06708

P: (203) 755-2999 F: (203) 755-6782

Release Records FROM:

____________________ Name

____________________ Address

____

____________________ Phone

Information to be released:

- I would like my **ENTIRE** medical record.

Reason for this release:

- Leaving practice
- Consent to speak to specialists, schools etc.
- Specialist
- Legal purposes- please specify exact dates of service: ____________________

**I understand that all balances must be paid in full prior to obtaining a copy of my medical records. I further understand that this request may take up to 30 days. I also understand the information disclosed could be re-disclosed by the recipient and then it is no longer protected by federal regulations.*

Date	Print Name	Signature	Relationship to patient