Pediatric Associates of Conn., P.C.

Authorization for Release of Medical Records FROM 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 FROM:

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

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

Release Records TO:

_____
Name

_____
Address

_____

_____
Phone

Information to be released:

- I would like my **ENTIRE** medical record. I understand that there is a fee of $0.45 per page copied/printed and the first 10 pages are free. The maximum charge for an individual complete record is $25. ***Please note we do not release or accept medical records on a disc, flash or thumb drive.***

- I would like a **SUMMARY** of my medical record. I understand this will include the last well exam, immunizations record, growth charts. There is no fee for a summary of records.

The following information will NOT be released without your initials on the line next to it:

Mental Health _____ HIV Testing/Status _____
Sexually Transmitted Diseases/Testing _____ Substance Abuse _____

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 this request may take up to 30 days. I also understand the information disclosed could be re-dislocated by the recipient and then it is no longer protected by federal regulations.*

_____ _____ _____ _____

Date Print Name Signature Relationship to patient