Center for Pediatric Medicine, PC
107 Newtown Road, Suite 1D
Danbury, CT 06810
203-790-0822
Fax: 203-790-1808

Authorization for Release of Health Information

Patient Name (Print)____ Date of Birth_____________________

Patient's Address:____

I hereby authorize (Name of Agency/Person)____

Address____

To release medical records to CENTER FOR PEDIATRIC MEDICINE, PC, 107 Newtown Rd., Suite 1D, Danbury, CT 06810

Specific information requested____

Approximate dates of treatment____

Please INITIAL the items below for release, if appropriate:

_______ Psychiatric Information _______Drug/Alcohol Information _______HIV-related information

I am making this request for transfer of my child's medical record because_______________________________

____

This authorization may be revoked by me at any time by a written notice to the Center for Pediatric Medicine, P.C. except to the extent that action has already been taken.

This authorization shall expire:

90 days from date of this request **OR** other (specify/date)_____________ **OR** until account is paid, whichever is later.

Refusal to authorize disclosure will in no way jeopardize your right to obtain present and future treatment except where disclosure is necessary for such treatment.

Patient's Signature____ Date______________________

* *

Patient is a minor, or patient is legally unable to sign because____

____ Date_________________________
(Print Name)

____ ____
(Signature of Authorized Person) (Relationship to Patient)

Disclosure Statement: This information is being disclosed to you from records whose confidentiality is protected by Federal and State law. Federal and State law prohibit you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains, or as otherwise permitted by law.