Hartford Area Pediatrics, P.C.
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Phone 860-678-9400 – Fax 860-678-9480

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

I hereby authorize Hartford Area Pediatrics, P.C. to _____Release _____Obtain my healthcare information.

****Note: There is a $25.00 fee per child for records****

Patient Information

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Home Address: _____

Phone number: _____

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New/Previous Practice Information (Please circle one)

Name of Practice: _____

Practice Address: _____

Practice Phone: _____ Fax: _____

****

Release of Records Only

Records to be released: ___ Entire medical records ___ Vaccine history and most recent physical note only (no fee)

Please check reason for transfer: ___ Family relocation ___ Insurance Change

___ Transfer to Adult Physician ___ Other

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The confidentiality of psychiatric, alcohol, and drug information is required under Chapter 899 of the Connecticut General Statues and Code 42 of the Federal Regulations. This information shall not be transmitted to anyone else without written consent or other authorization as provided by these regulations. This authorization may be revoked at any time, except to the extent that action has already been taken in compliance with this request. This authorization, unless expressly revoked earlier, expires in 6 months from the date signed below. Disclosure of any of this information by the recipient is prohibited without further written consent.

_____

Signature of Parent/Legal Guardian or Patient (if over 18 years of age) Date

_____

Printed name of Parent/Legal Guardian or Patient (if over 18 years of age) Relationship to patient