

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print Patient's Full Name)

(Birth Date: mm/dd/yyyy)

(Street Address)

(Cell Phone Number)

(City, State, Zip Code)

(Home Phone Number)

At the request of the individual, I _____, do hereby authorize:

(Name of Facility/Previous Doctor's Office)

(Address of Facility/Previous Doctor's Office including State and ZIP Code)

(Phone/Fax Number of Facility/Previous Doctor's Office)

To release:

___ Progress notes ___ Pathology Reports ___ Other Doctor Notes ___ Lab Reports ___ OB/GYN Notes ___ All Records
___ Radiology Reports ___ Hospital Notes ___ ECG/EEG/Cardio ___ Other: _____

I Do / Do Not: Authorize release of information related to AIDS/HIV, or any other communicable diseases, psychiatric care, and/or psychological assessments, along with treatment for alcohol and/or drug abuse.

Information Release To: Central Connecticut Pediatrics LLC

742 Worthington Ridge

Berlin, CT 06037

(P) 860-829-7337

(F) 860-829-2295

Purpose of disclosure: ___ Referral to Specialist ___ Insurance ___ Worker's Comp ___ Legal Investigation
___ Disability ___ Personal ___ Relocated ___ Other (specify): _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring: _____

I understand that I am solely responsible for any fees incurred in copying and/or obtaining these Records.

Signature of individual or guardian or personal representative

Relationship to patient Date: _____