

PREFERRED PEDIATRIC

**88 Noble Ave
Milford, CT 06460
203 874-2800**

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

DATE: _____

PATIENT INFORMATION (PLEASE PRINT):

PATIENTS NAME: _____

PATIENTS DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY/STATE/ZIP CODE: _____

PHONE NUMBER: _____

RELEASE MEDICAL RECORDS TO: _____

ADDRESS OF RECIPIENT: _____

CITY/STATE/ZIP CODE: _____

MAIL RECORDS WILL PICK UP RECORDS

INFORMATION REQUEST:

ALL MEDICAL RECORDS

IMMUNIZATION RECORDS

OTHER: _____

REASON FOR REQUEST OF MEDICAL RECORDS:

RELOCATION

DISSATISFACTION OFFICE OR MEDICAL CARE

OTHER: (PLEASE SPECIFY) _____

SIGNATURE: _____ **DATE:** _____

(of patient or legal guardian, if patient is a minor. Patients 18 years and older must sign for themselves).

PLEASE RESING BELOW FOR HIGHLY CONFIDENTIAL INFORMATION TO ALSO BE RELEASED:

SIGNATURE: _____ **DATE:** _____

By signing my name I authorize the release of all highly confidential information including Mental Illness or Developmental Disability, HIV/AIDS test results and Substance (drug or alcohol) Abuse.

AUTHORIZATION IS VALID FOR 30 DAYS, UNLESS REVOKED BY THE PATIENT