Pedi Care
Pediatrics Seven Days a Week

Records Transferring into Pedi-Care From:

Name of Medical Facility: _____

-OR-

Doctor's Full Name: _____

Phone Number: (_____)_____

Fax Number: (_____)_____

Address: _____

I hereby authorize the above doctor or medical facility to transfer the medical records specified below to Pedi-Care.

Patient(s) Last Name(s):
Patient(s) First Name(s):
Date(s) of Birth:
Phone Number: ( )
Type of Records Requested (e.g., all medical):

Today's Date: ____/____/_____

I understand that I may cancel this authorization at any time, in writing. However, if Pedi-Care has already used this authorization, I may be unable to cancel the authorization. I understand that the practice will not condition treatment of payment based upon my signing this authorization until which time the records have been transferred from Pedi-Care to the party named above. I am signing this authorization freely. No one has forced me to sign this authorization. I understand that the information disclosed could be re-disclosed by the recipient, and then it is no longer protected by federal regulations. I understand that if the information disclosed is related to any or all of the following: HIV/AIDS, ALCOHOL/SUBSTANCE ABUSE, and/or any sensitive information, that the recipient may not re-disclose it under Connecticut State Law. I have reviewed this authorization. I understand it. I may request a copy of this authorization in writing. I accept these terms.

Parent/ Guardian's Signature (Patient may sign if aged 18 years or older.):

X_____

Please print your name here: _____

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