



1301 Farmington Ave
Bristol, CT 06010
Phone: (860) 589-4501
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AUTHORIZATION TO DISCLOSE/RELEASE/OBTAIN HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Parent or Guardian Name (if patient is under 18): _____

Telephone Number: _____

INFORMATION REQUESTED

I authorize The Pediatric Care Center, LLC to DISCLOSE/ RELEASE health information to:

I authorize The Pediatric Care Center, LLC to OBTAIN all medical records from:

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

TELE#: _____

TELE#: _____

FAX#: _____

FAX#: _____

INFORMATION TO BE DISCLOSED:

____ Entire Record ____ Lab Results ____ Radiology Results ____ Appointments

____ Clinical Notes ____ Medications ____ Billing Records

____ Other: _____

THE PURPOSE OF THIS REQUEST IS:

____ Transferring care to new provider, if so reason: _____

____ Coordinate care with specialist ____ Legal ____ Disability

____ Other: _____

AUTHORIZATION:

I hereby authorize the release of my own or my child's records as described above, including AIDS/ HIV, sickle cell anemia, behavioral health/ psychiatric, drug abuse and/ or alcohol related information, if applicable.

I understand that I have the legal right to revoke this authorization at any time by notifying The Pediatric Care Center, LLC in writing, except to the extent that (a) action has been taken in reliance on this authorization or, (b) this authorization is obtained as condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or policy itself. Unless otherwise revoked. This authorization will be valid for a period of one year from the date below or on the following date, event or condition: _____

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by the federal privacy regulations. I understand that my treatment or continued treatment by The Pediatric Care Center, LLC is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that I may inspect or copy the information to be used or disclosed. I understand that authorizing information is voluntary. The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.

Signature of Patient/Parent / Legal Representative

Date