Village Pediatrics
323 Riverside Avenue, 2nd Fl.
Westport, CT 06880
(203)221-7337
Fax: (203)291-0830

Authorization to Release/Transfer Medical Records

I hereby authorize the release of my child's medical records:

My son/daughter's (circle one) name is:

_____ _____
(Patient's full name) Date of birth

My son/daughter's (circle one) name is:

_____ _____
(Patient's full name) Date of birth

My son/daughter's (circle one) name is:

_____ _____
(Patient's full name) Date of birth

My son/daughter's (circle one) name is:

_____ _____
(Patient's full name) Date of birth

Please release these medical records to:
VILLAGE PEDIATRICS
323 Riverside Avenue, 2nd Fl.
Westport, CT 06880

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

Print Name (parent/guardian): _____

Email: _____ Phone #: _____

Signature: _____ Date: _____

Please turn over

Please Note: *In order for Village Pediatrics to ensure that we receive your family's medical records in a timely manner, we ask that you complete this side of the form so we can forward it to your previous medical practice.*

Thank you for your cooperation.

Practice Name: _____

Primary Care Physician: _____

Office Address: _____

_____

(*City*) (*State*) (*Zip*)

Phone #: _____

Fax #: _____