Village Pediatrics
323 Riverside Avenue
Westport, CT 06880
(203)221-7337

Authorization to Release/Transfer Medical Records

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

My son/daughter's name is ____
(Patient's full name) (Date of Birth)

My son/daughter's name is ____
(Patient's full name) (Date of Birth)

My son/daughter's name is ____
(Patient's full name) (Date of Birth)

My son/daughter's name is ____
(Patient's full name) (Date of Birth)

Please release these records to: ___________________________
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(*Please indicate the name of a medical practice as we are unable to release records to parents unless indicated that you are moving out of the country.)*

Today's date: ____________________

Print name (parent/guardian) __________________________

Signature____

Phone#____

Please Note: In an attempt to save paper, we are now printing all medical records on a CD at a flat rate of $15 **per child**. Please advise our office staff if you would prefer records to be printed on paper at a rate of $0.65/page (*Added Benefits cannot be applied to this option*).