Pediatric Associates of Cheshire

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TRANSFER OF MEDICAL RECORDS

Patient Information

Name: _____ Date of Birth: ____/____/_____

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Reason for Release:

☐ Adulthood
☐ Moved to: _____
☐ Dissatisfied: _____
☐ Other: _____

Release Medical to:

☐ Pick Up
☐ Mail Records to: _____
Name of New Physician

_____
Address

_____
City State Zip Code

_____
Phone Number

Information to Release

☐ Immunization Records Only
☐ Complete Medical Records
☐ Records for dates of Treatment from ____/____/_____ to ____/____/_____

I hereby authorize Pediatric Associates of Cheshire, PC to release the medical records and protected health information for the above patients as indicated. By completing this request to transfer records I release Pediatric Associates of Cheshire, PC from any further medical responsibility for the above patients. This authorization is valid for one year unless revoked in writing by the patient or legal guardian.

Signature of Legal Guardian or Patient (if over the age of 18) Date

Printed Name Relationship to Patient