Pediatric Associates of Cheshire
435 Highland Avenue Suite 110
Cheshire, CT 06410
203.272.0396

REQUEST FOR MEDICAL RECORDS

Date: _____

To: _____
(Name of Individual/Facility Name)

_____
(Street Name)

_____
(City, State, Zip Code)

_____
(Phone Number/Fax Number)

Please forward all medical records for the following patient(s) to the above address:

_____ _____
(Patient Name and D.O.B) (Patient Name and D.O.B)

_____ _____
(Patient Name and D.O.B) (Patient Name and D.O.B)

_____ _____
(Patient Name and D.O.B) (Patient Name and D.O.B)

_____
(Signature of Parent or Patient if over the age of 18)

CONFIDENTIALITY NOTICE

This document contains information which is confidential. The information is intended only for the use of the individual or entity named on this sheet. If you receive this in error, please notify this office. Thank you.