PEDIATRIC ASSOCIATES OF WESTERN CONNECTICUT

LEON A. BACZESKI, MD
DAVID B. GROPPER, MD
BRUCE W. COHEN, MD
RACHEL R. ROTHSCHILD, MD
JAMIE L. ALON, MD
LEAH A. STERRY, DO
AARON M. SLAIBY, DO
JOSE F. ARRAIANO, PA-C
ANNE-MARIE VOGT, APRN
EMMA G. HANRAHAN, PA-C
NICOLE A. WOERING, APRN

41 GERMANTOWN ROAD
DANBURY, CT 06810

PHONE: (203) 744-1680
FAX: (203) 792-6510

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

PATIENT INFORMATION:

DATE:	**DOB:**
PATIENTS NAME (PLEASE PRINT):	
STREET ADDRESS:	
CITY/STATE/ZIP CODE:	**PHONE NUMBER:**

RELEASE MEDICAL RECORDS TO:
ADDRESS OF RECIPIENT:
CITY/STATE/ZIP CODE:

MAIL (Out Of State Only) **PICK UP**

INFORMATION REQUEST:

ALL MEDICAL RECORDS
RECORDS PERTAINING TO SPECIFIC DATE OF SERVICE: From_____To_____
IMMUNIZATION RECORDS
OTHER: _____

REASON FOR TRANSFER:

RELOCATION
CHANGE OF INSURANCE: _____
DISSATISFACTION OFFICE OR MEDICAL CARE
OTHER: (PLEASE SPECIFY) _____

SIGNATURE: _____ **DATE:**_____
(of patient or legal guardian, if patient is a minor. Patients 18 years and older must sign for themselves).

HIGHLY CONFIDENTIAL INFORMATION:

SIGNATURE: _____ **DATE:**_____
By signing my name I authorize the release of all highly confidential information including Mental Illness or Developmental Disability, HIV/AIDS test results and Substance (drug or alcohol) Abuse.

AUTHORIZATION IS VALID FOR ONE YEAR, UNLESS REVOKED BY THE PATIENT.