

# **PEDIATRIC ASSOCIATES OF WESTERN CONNECTICUT**

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## **AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION**

### **PATIENT INFORMATION:**

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

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

**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.***