Records Release Form

$15 per child

Valley Pediatrics of Greenwich
25 Valley Drive
Greenwich, CT 06831

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Patient: _____ **DOB:** _____

Name of Patient: _____ **DOB:** _____

Name of Patient:_____**DOB:**_____

Name of Patient:_____**DOB:**_____

Name of Patient:_____**DOB:**_____

I authorize Valley Pediatrics of Greenwich to release protected health information with respect to my treatment, including information relating to the diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV/Aids related information, to:

Name:_____

Address:_____

_____

We will contact you when your copies are ready to arrange for pick up.

THIS IS A TRANSFER_____**YES** _____**NO**

REASON_____

The nature, description, and extent of information to be disclosed is (i.e., dates of services, services provided, and level of detail):

_____

_____

I understand that Valley Pediatrics of Greenwich will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure unless my treatment is related to research.

This authorization is subject to revocation at any time by sending written notification of such revocation to the Office Manager of Valley Pediatrics of Greenwich and that such revocation is not effective to the extent that Valley Pediatrics of Greenwich has taken any action in accordance with and in reliance upon this authorization. I further understand that information released pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or state law.

This authorization shall expire 180 days after the date appearing below.

Date: _____

_____

Signature of Patient/Person Granting Authorization on Behalf of Patient

1`CANCEL ALL APPOINTMENT BEFORE LEAVING PRACTICE