New Canaan PEDIATRICS
173 East Avenue, New Canaan, CT 06840

HIPAA Release of Records Request – Not Transferring

Patient Name_____Date of Birth_____

Patient Name_____Date of Birth_____

Patient Name_____Date of Birth_____

☐ Please release all records for my child(ren).

☐ Please release the following records:

_____

_____

_____

Reason For Medical Records Request:

☐ Referral to specialist ☐ Personal

Please note: The State of Connecticut privacy laws require that if the patient is 18 years old or older they must sign the request form in addition to the parent or guardian.

☐ I will pick up my records on _____Please allow 7-10 business days for records.

☐ Please mail my records in the accompanying self-addressed envelope.

Best phone number in case we need to reach you _____

Parent/Guardian Signature_____Print Name/Date_____

Patient 18 years or older Signature_____Print Name/Date_____

Patient 18 years or older Signature_____Print Name/Date_____