New Canaan PEDIATRICS

173 East Avenue, New Canaan, CT 06840

HIPAA Transfer of Records Request

Patient Name_____DOB:_____

Patient Name_____DOB:_____

Patient Name_____DOB:_____

Patient Name_____DOB:_____

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

☐ Please release only the following records: _____

_____

By completing and signing this medical records/transfer request, I release New Canaan Pediatrics from any further medical responsibility for my child (ren). I understand that I will be charged no more than $0.65 per page for a paper copy as allowed by the State of Connecticut unless Medicaid rules apply.

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. Please note privacy information may be deleted at the discretion of your child's physician.

☐ 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.

Phone Number in case we need to reach you. _____

Reason for Leaving?_____

Parent/Guardian Signature_____Print Name/Date_____

Patient 18 years or older Signature_____ Print Name/Date_____