SOUTHINGTON PEDIATRIC ASSOCIATES
209 MAIN ST. SUITE A
SOUTHINGTON , CT 06489
Phone #: 860-621-8331

RECORDS RELEASE TRANSFER

I_____hereby authorize:
(Parent/Guardian/Patient 18 yrs or older)

Doctor/office_____
Address_____
_____
Phone # _____Fax #_____

To release all medical records pertaining to:

Patient's Name:_____

Patient's Date of Birth:_____

Please MAIL all medcial records including growth charts, physcial exams, immunization records, recent labs and x-ray reports and any other pertinent information.

PLEASE DO NOT FAX RECORDS

Thank You

Signature of parent/guardian_____Date_____

SOUTHINGTON PEDIATRIC ASSOCIATES
209 MAIN ST.
SOUTHINGTON, CT 06489
TEL # 860 621-8331
FAX #-860 621-5169

RELEASE FOR RECORDS TRANSFER

I _____ hereby authorize:
(Parent/guardian name/patient 18 yrs. or older)

SOUTHINGTON PEDIATRIC ASSOC.
209 MAIN ST, SUITE A
SOUTHINGTON, CT 06489

to release all medical records pertaining to _____

Patient's date of birth _____

Please transfer all records including growth charts, physical exams, recent lab and x-ray reports and any other pertinent information to:

Doctor _____

Street Address _____

City, State, & Zip Code _____

Signature of parent/guardian/patient _____

Date _____