

CANTERBURY PEDIATRICS

401 MONROE TURNPIKE · MONROE, CT 06468
203-452-1063 FAX 203-445-8926

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____

____ This is an authorization for Canterbury Pediatrics to obtain medical information from the physician/organization named below.

____ This is an authorization for Canterbury Pediatrics to release medical information to the physician/organization named below.

Reason for record release: _____

Physician/Organization Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

**THIS RELEASE REQUESTS ALL RECORDS IN YOUR POSSESSION,
INCLUDING, BUT NOT LIMITED TO, IMMUNIZATION RECORDS AND LABORATORY TESTING RESULTS**

Name: _____ Signature: _____

Relationship to Patient: _____ Phone: _____

Witness Signature: _____ Date: _____

Completed by: _____ Date: _____ Mailed: _____ Faxed: _____ Picked Up: _____

It is the policy of Canterbury Pediatrics to release only those records that are generated in this office. We cannot guarantee that all pertinent information from outside sourced are present in this patients chart. Please contact the patient if any additional records are needed from other physicians or hospitals. This authorization is valid for 180 days from the date listed above.