Email:
pspoffice@pspkids.com

Park Street Pediatrics, LLC

Phone: 203-840-7566
Fax: 203-840-7569

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Release of Medical Records

Name of Child(ren): Name: ______________________ DOB: ______________
Name: ______________________ DOB: ______________
Name: ______________________ DOB: ______________
Name: ______________________ DOB: ______________

Reason for Transfer ( ) Insurance Change: (name of insurance) ______________________
(Please Check One) ( ) Moved: (date of move/new contact info) ______________________
( ) Adulthood: (new doctor) ______________________
( ) Dissatisfied: (reason) ______________________
( ) Other: ______________________

By completing and signing this transfer request, I release Park Street Pediatrics from any further medical responsibility for my child(ren). I understand that I am responsible for picking up these records within 30 days of when records are copied and that it is my responsibility to forward these records to my new provider. **I will be contacted at the number I provide below** when the records are ready. *If these records are not picked up within 30 days, they will be mailed directly to my home address and I will be responsible for the cost of postage*. To insure continuity of medical care, we request that you provide the following information:

Name and address of new physician: ______________________

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Please note: State of Connecticut privacy laws require that if this request includes any child 14 years of age or older, it must be signed by that child in addition to parent or guardian, since there may be confidential information that the child does not wish to share with anyone other than their physician. **NOTE: Any child 18 years or older MUST sign their own separate form.**

______________________ (Child 14 or older) Date ______________________ (Child 14 or older) Date

______________________ (Child 14 or older) Date ______________________ (Child 14 or older) Date

I also understand that there is a $15.00 fee for copying and processing that will be charged for each child's records. Payment is requested at the time this form is submitted. *(Applies to patients transferring out only)*. Records requested for personal use the fee is .65 cents per page.

** ______________________ ________ ______________________
Signature of Parent/Guardian (Patient if 18+ yrs) Date Current address and phone (or new information if moved) – PHONE # REQUIRED

Please indicate your method of payment for processing this request: Amount Due: ______________

Please charge my: ____VISA ____MC ____DISC ____AMEX or ____CASH ____CHECK

Card# ______________________ Expiration: ______________

CVV #: ____________ Cardholder signature: ______________________

Name of Alternate party to pick-up records: ______________________ Initial: ________

** Do Not Sign Below Until Picking Up Records **

Note: Records must be picked up by parent/patient/guardian unless authorization is given in writing, in which case written authorization must be presented along with a valid picture ID for the person named in the authorization.

Records Picked Up On: ______________ By: ______________________
Date Signature of Parent or Guardian (Patient if 18 yrs or older)