



TOLLAND COUNTY PEDIATRICS
231 MERROW RD. #3915
TOLLAND, CT 06084
TELEPHONE: 860-875-9856
FAX NUMBER: 860-875-9868

AUTHORIZATION OF RELEASE OF HEALTH INFORMATION

WHAT INFORMATION ARE WE DISCLOSING TO THE NEW PRACTICE?

- ENTIRE MEDICAL RECORD
- IMMUNIZATION RECORD
- LAST PHYSICAL EXAM NOTES
- LAB RESULTS

<p>Are you transferring out of Manchester Pediatrics and terminating your patient status here?</p> <p><input type="radio"/> YES <input type="radio"/> NO, JUST INFORMATION</p>
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PATIENT INFORMATION

PATIENT'S FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____

PATIENT'S FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____

Option A

I, _____ AUTHORIZE MANCHESTER PEDIATRIC ASSOCIATES TO DISCLOSE PROTECTED HEALTH INFORMATION TO THE FOLLOWING ORGANIZATION:

DOCTOR'S OFFICE NAME: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

HOW WOULD YOU LIKE THE MEDICAL RECORDS TO BE RELEASED TO THE NEW FACILITY

- COPIES BY MAIL (50 CENTS PER PAGE)
- COPIES BY FAX
- BURNED TO A CD (\$5)

Option B

I, _____ AUTHORIZE MANCHESTER PEDIATRIC ASSOCIATES TO DISCLOSE PROTECTED HEALTH INFORMATION TO ***MYSELF/RESPONSIBLE PARTY OF PATIENT ABOVE***

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT THE HEALTH CENTER MAY NOT CONDITION MY TREATMENT BASED ON THIS AUTHORIZATION. I UNDERSTAND THAT MPA WILL CHARGE ME 50 CENTS PER PAGE FOR ANY PRINTED RECORDS AND A FLAT FEE OF \$5.00 FOR ANY CD. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITTEN REQUEST EXCEPT WHEN THE INFORMATION HAS ALREADY BEEN RELEASED BASED ON MY AUTHORIZATION. THIS AUTHORIZATION IS VALID FOR ONE YEAR AFTER THE DATE IT HAS BEEN SIGNED.

Signature of Parent/Responsible Party

Date