MANCHESTER PEDIATRIC ASSOCIATES LLC
2701 TAMARACK AVENUE
SOUTH WINDSOR, CT 06074
TELEPHONE: 860-647-8282
FAX NUMBER: 860-647-8399

Authorization to Release Medical Record Information

Patient Name _____ Date of birth _____ Phone number _____

I Authorize information to be released FROM:

Practice Name/Address:

_____

_____

Telephone: _____ Fax: _____

Please send all medical records to (for protected information inclusion, see below) *:

Manchester Pediatric Associates LLC
2701 Tamarack Ave
South Windsor, CT 06074

Telephone: 860-647-8282
Fax: 860-647-8399

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by state/federal law. By initialing I authorize the release of the following protected or sensitive information:

_____ AIDS/HIV test results
_____ Alcoholism/Drug abuse treatment
_____ Genetic Testing
_____Mental health diagnosis/treatment (including ADD/ADHD

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

***ATTENTION CORRESPONDING FACILITY** – if releasing records for multiple patients in the same family, please send each patient record separately.

Name of responsible Party _____ Relationship to patient _____

Signature of responsible Party _____ Date _____