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 Manchester Pediatric Associates LLC to release general medical records/information TO (for protected information inclusion, see below):

Practice Name/Address:

_____

_____

Telephone: _____ Fax: _____

Purpose of disclosure (please check appropriate box):

☐Personal Use ☐Outside Referral ☐Changing Primary Care Physician/Clinic Effective _____
☐Legal ☐School ☐Coordination of Care
☐Verbal Communication ☐Other (specify)_____

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 _____ Genetic Testing
_____ Alcoholism/Drug abuse treatment _____Mental Health Diagnosis/Treatment (including ADD/ADHD)

Please indicate below how you would like your medical records to be released:

☐Copies by mail (50 cents per page) ☐Copies by fax ☐Copies by CD ($5) ☐Copies by USB ($15)

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.

Name of Responsible Party _____ Relationship to Patient _____

Signature of Responsible Party _____ Date _____