PEDIATRIC HEALTHCARE ASSOCIATES
(203) 452-8322

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: Doctor's Name _____
Address _____
_____
Phone: _____ Fax: _____

Please send ALL medical records on my children:

Name _____ DOB: _____

Name _____ DOB: _____

Name _____ DOB: _____

Name _____ DOB: _____

To the following office:

____ 4699 Main Street, Bridgeport, CT 06606

____ 50 Unquowa Place, Fairfield, CT 06824

____ 4 Corporate Drive, Shelton, CT 06484

____ 2876 Main Street, Stratford, CT 06614

____ 15 Corporate Drive, Trumbull, CT 06611

_____ Date: _____
Parent/Guardian Signature

Parent/Guardian name and address:

_____

_____

Home Phone: _____ Cell Phone: _____