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:

_____ 99 Hawley Lane, Stratford, CT 06614

_____ 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: _____