East Lyme Pediatric Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Connecticut law, this practice may not use or disclose you're individually identifiable health information without your authorization except as provided in our Notice of Privacy practices. Your completion of this form means that you are giving us, East Lyme Pediatric Clinic, permission to obtain health records information on the below mentioned child. This information will allow us to provide healthcare services to them.
I hereby authorize East Lyme Pediatric Clinic to obtain health information concerning:

Patient Name:	D.O.B.
1. ______________________________	_______/__________/______________
2. ______________________________	_______/__________/______________
3. ______________________________	_______/__________/______________
4.______________________________	_______/__________/______________

Description of health information to disclosed/obtained ____

The types of information below cannot be release/obtained without my specific consent and knowledge, Therefore, I have initialed before each type of record I authorize you to release/obtain:

________________ Alcohol and / or drug abuse treatment records

________________ Mental health treatment records

________________ AIDS , ARC , HIV testing

________________ Drug and / or alcohol testing records

__________ The information disclosed/ obtained is for purposed of transferring my child to East Lyme Pediatric Clinic.

__________ The information disclosed/obtained is for purpose of continued health care.

Please mail the above information to:

East Lyme Pediatrics Clinic
170 Flanders Road
Niantic, CT 06357
Tel: (860) 739-7444
Pease fax the above information to **(860) 739-3252**

Signed: ____ Date: _____________________

Print Name: ____ Relationship to PT:_______________

Records Request from: __________________________________ Phone ______________________
Fax______________________