



The Pediatric Care Center, LLC

Susan Adeyinka, MD, FAAP

RELEASE FOR RECORDS TRANSFER

I, _____, hereby authorize:
(Parent/ Guardian's Name, Patient over 18y)

Doctor: _____
Street Address: _____
City, State, & Zip: _____

To Release all Medical Records pertaining to: _____

Patient's date of birth: _____

Please transfer all records-including copies of growth chart, progress notes, physical exams, lab and x-ray reports and any other information or reports in patient's record to:

Doctor: _____
Street Address: _____
City, State, & Zip: _____

The confidentiality of this record is protected by the Federal Confidentiality Regulations 42 CFR (part 2) and Chapter 899C of the Connecticut General Statutes.

This information shall not be transmitted to anyone else without written consent or other authorization as provided in the statutes. The refusal to grant this consent will in no way jeopardize your right to obtain present or future treatment except where disclosure of such communications is necessary for treatment of such patient. The signature on this authorization shall be valid for one year. This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance upon it.

Phone numbers where the parent/guardian can be reached during the day:

- 1) _____
- 2) _____

Signature of patient/guardian: _____
Date: _____