Healthy Roots Pediatrics
27 Hilliard Street, Manchester CT 06042
Phone: 860-646-3903 Fax: 860-645-3492

Authorization for Release of Medical Records/ Transferring into Practice

I authorize the office of:

Name: _____

Phone: _____

Fax: _____

to release medical records to the office of **Healthy Roots Pediatrics** for transferring into the practice. This includes any pertinent office notes, diagnostic testing, specialist notes, immunization records, growth charts and copy of the last yearly physical examination.
Fax to: 860-645-3492

Additional comments: _____

Patient's Name: _____ D.O.B.: _____ / _____ / _____

Patient's Name: _____ D.O.B.: _____ / _____ / _____

Patient's Name: _____ D.O.B.: _____ / _____ / _____

Patient's Name: _____ D.O.B.: _____ / _____ / _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____ / _____ / _____

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