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

Authorization for Release of Medical Record/ Transfer out

PATIENT'S NAME: _____

D.O.B. _____ / _____ / _____

Please release medical records to:

Name: _____

Address: _____

Phone: _____ Fax: _____

☐ **Release of medical record** ☐ **Transfer out of practice**

Please be aware that we can transfer pertinent records including immunizations, last physical information, growth charts, any recent positive labs and recent specialist notes at no charge; however, there will be a charge of $0.65 per sheet if you request the entire record plus the additional cost of first-class postage. If special mailing is required an additional charge of $15.00 will be assessed. Payment will be due before records are released.

_____ Please transfer only pertinent records.

_____ Please transfer entire medical record at $0.65 a sheet.

IF OVER 18:

Patient signature: _____

Date signed: _____ / _____ / _____

IF UNDER 18:

Parent/Guardian Name: _____

Parent/Guardian signature: _____

Date signed: _____ / _____ / _____

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