Pediatric Health Associates, P.C.

Sachin Dhingra, MD, FAAP

576 Farmington Ave. Suite 2W
Hartford, CT 06105
Phone: (860) 266-4477 Fax: (860) 270-0616

MEDICAL RECORDS RELEASE

Patient's Name:_____ **Last Name:**_____

Date of Birth:_____ **S.S:**_____

Street Address:_____

City:_____ **State:**_____ **Zip-code:**_____

I Hereby authorize the release of my medical records FROM:

Name of Agency/Person:_____

Street Address:_____

City:_____ **State:**_____ **Zip-code:**_____

Approximate date(s) to be included:_____

Type of Treatment:_____

Connecticut State Law requires that specific written consent be given for the release of medical records containing information about HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immunodeficiency Virus).

Please initial for the release of the following information:

_____Medical records with HIV related information
_____Medical records with drug/alcohol information

Information to be released TO:

Pediatric Health Associates, P.C.
576 Farmington Ave.
Suite 2W
Hartford, CT 06105

I understand that these records are being released to Pediatric Health Associates, P.C., for the purpose of further or continuing medical treatment of above named patient. This authorization will expire in 180 days from the date appearing below. I understand that I may revoke this authorization at any time by notifying Pediatric Health Associates, P.C in writing but if I do, it will not have any effect on that actions the office has taken before receiving the revocation.

Signed:_____ **Date:**_____

Print:_____ **Relation to Patient:**_____