MILFORD PEDIATRIC GROUP
321 BOSTON POST ROAD
MILFORD, CT 06460

PATIENT DIRECTED RELEASE OF RECORDS DIRECTLY TO MILFORD PEDIATRIC GROUP

Patient Name: ______________________________ DOB: __________

Patient Name: ______________________________ DOB: __________

Patient Name: ______________________________ DOB: __________

Patient Name: ______________________________ DOB: __________

Home Address (for verification): ______________________________

______________________________ Phone Number: ______________________________

I hereby request a copy of the medical records for the above named patients, as contained in the designated record set of ______________________________ ("Practice"), be made available to MILFORD PEDIATRIC GROUP at the above address.

SECTION 1. Scope and Format.

Scope of records requested: ______________________________

Reason records requested: ______________________________

- o The entire record
- o Only a portion of records (describe): ______________________________

Format I wish to receive is: Copied CD Flash drive

The format may be paper, electronic, or mixed depending on how it is maintained. It may also be on your copy format preferences. Please check with our staff to discuss the options available for paper and/or electronic copies.

Section 4. Patient Signature Required:

______________________________ Date: ______________________________

Signature of Patient/Client or his/her Authorized representative, or parent if a minor

Relationship to Patient(s): ______________________________ PHONE: ______________________________