# MEDICAL RECORD RELEASE FORM

West Hartford Pediatrics, LLC
785 Farmington Avenue
West Hartford, CT 06119
Phone (860) 523-4100
Fax (860) 523-1462

Please transfer the medical records of the patient(s) listed below to the following address:

_____

_____

_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

**Please allow up to 30 days for records to be prepared.**

**There is a $.65 per page convenience fee for complete copies of medical records.**

**There is no charge for the most recent Physical Exam information including growth chart and vaccine history.**

Please select one: _____ Complete medical records _____ Vaccine history and PE with growth chart only

Reason for leaving:_____

Parent/Guardian's Signature:_____ Date:_____

Medical records cannot be released until this form is completed and signed by the parent or legal guardian.