PEDIATRIC ASSOCIATES OF FARMINGTON, LLC
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Printed Name: _______________________________________ **Date of Birth:** _____________

I authorize____

Tel. No.; _________________________________ **Fax No.;** ______________________________ to release
□ Immunization records

□ My entire medical record to include (Office Notes, Results of Diagnostic Testing {i.e., x-rays, EKG, laboratory testing}, correspondence from other providers, and past medical records-different provider.)
I also request that the following information be released: (check) □ HIV Testing and related treatment
□ Psychiatric notes □ Drug and / or Alcohol Counseling / Testing □ Genetic Counseling and / or testing.

TO: **Pediatric Associates of Farmington, LLC / Dr. Deepa Limaye /Lisa Petricca, PA-C**

Address: 200 Mountain Road, Farmington CT 06032 Tel. (860) 676-9000 Fax # (860) 676-1541

For the purpose of: Transfer of care / Communication / Developmental assessment ______________________
Please □ fill rating scales □ Send recent IEP and evaluations done □ Call Dr. Limaye to discuss care__________

I authorize **Dr. Deepa Limaye / Pediatric Associates of Farmington, LLC** to release my medical records to □ **Self**

□ ______________________________________ **Tel No.;** _______________ **Fax No.;** _____________

To be used for the purpose of: Transfer of care / ____

Special Mailing Instructions: ____

Per Pediatric Associates of Farmington, LLC HIPAA Policy 0003- ***The charge for copying of Medical Records is 0.65 cents per page plus the cost of first class postage, with a maximum charge of $75.00 per chart, per request. If special mailing is required, an additional charge of $ 15.00 will be assessed. Exception: The first request from a patient for records from the office will be copied at no charge. Second and subsequent requests will be charged as noted above.***

Signature: _______________________________________ Date: ____________________________
(Signature of person granting authorization on behalf of patient. Parent or guardian if patient is under 18 years of age)

Witness: ____ Date: ___________________________

HIV Related Information: " This information is disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is not sufficient for this purpose."

Drug and / or Alcohol: I may revoke this authorization at any time, except to the extent that action has been taken thereon. This authorization, unless expressly revoked earlier, expires on ________________________. PL9-282 Sec. 52-146

Psychiatric: The confidentiality of a psychiatric record is required under Connecticut General Statutes. This information shall not be transmitted to anyone else without written consent or other authorization as provided by CGS. CGS Sec 52-146

10/21/2020 Pediatric Associates of Farmington, LLC may alter, amend or replace their Policies & Procedures or portions of their Compliance Plan at any time.