NEXT GenerationPediatrics

Authorization to Release Health Information

Patient Name _____ Date of Birth _____

Telephone _____

Other Names Patient has Used _____

Send Records to: Next Generation Pediatrics., LLC

644 West Putnam Ave, Suite 203

Greenwich, CT 06830

(203) 661-6430 Phone

(203) 661-2597 Fax (or) Call to email directly

I [ ] do [ ] do not authorize this information to be faxed.
If yes, fax number: (203) 661-2597

If you are not able to fax all records directly to the above physician office,
I _____ also at this time give authorization for the records to be emailed directly to the physician.

This information is being disclosed for the purpose of Continuing Health Care.

Complete Health Record to be disclosed or (check appropriate boxes):
[ ] History & Physical Exam [ ] Progress Notes [ ] Discharge Summary
[ ] X-Rays / Ultrasounds [ ] Laboratory Tests [ ] Consultations

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.