Farmington Valley Pediatrics, LLC

Cindy St. Onge, M.D.
Pediatrics and Adolescent Medicine
30 W. Avon Rd., Suite D - Avon, CT 06001
Phone: (860) 678-0484 Fax: (860) 678-1454

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

Patient Name:_________________________________ Date of Birth:______________

I hereby authorize **Farmington Valley Pediatrics, LLC** to RELEASE/OBTAIN the following information to/from: Entity Name____

Address____

Telephone#____________________ Fax#____________________

IF MORE THAN 20 TOTAL PAGES PLEASE DO NOT FAX

Please Release the Following Information

- All Pertinent Medical Information
  - History and Physical
  - Progress Notes
  - Discharge Summaries
  - Laboratory and X-ray reports
  - Other_________________
  - Operation Reports
  - Immunizations
  - Psychiatric Information
  - Drug and Alcohol Information
  - HIV – related Information

Purpose of need for information:

- Continuity of Medical Care
- Other_________________________________

Specific Information to be included:______________________
Dates of Treatment to be included:______________________

The confidentiality of psychiatric, alcohol and drug information is required under Chapter 899 of the Connecticut General Statutes and Code 42 of the Federal Regulations. This information shall not be transmitted to anyone else without written consent or other authorization as provided by these regulations. This authorization may be revoked by me at any time, except to the extent that action has already been taken in compliance with this request. This authorization, unless expressly revoked earlier, expires in six (6) months from the date signed below. Disclosure of any of this information by the recipient is prohibited without my further written consent.

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Signature of Patient (or Parent (s) / Guardian or Legal Representative of Parent (s).

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Relationship to Patient   Signature of witness   Date