THE CENTER FOR ADVANCED PEDIATRICS

40 Cross Street Norwalk, CT 06851
85 Old Kindgs Highway North Darien, CT 06820
901 Ethan Allen Highway, Ridgefield, CT 06877

REQUEST OR TRANSFER OF MEDICAL RECORDS from The Center for Advanced Pediatrics

PT NAME:__________________________ DOB:____________ Last Visit:____________
PT NAME:__________________________ DOB:____________ Last Visit:____________
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PT NAME:__________________________ DOB: ____________ Last Visit:____________

REASON FOR MEDICAL RECORDS REQUEST:

____ Transferring out of Practice

____ For Referral Visit to another Physician :________________ If visit scheduled (date/time):____________

REASON FOR TRANSFER OF MEDICAL RECORDS:

____ Dissatisfied (Please let us know what has concerned you so we may make improvements in the future)

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____ Insurance Change (Name of main insurance) ______________________

____ Adulthood (Name of new Physician/practice)______________________

____ Other: ______________________

By completing and signing this medical records/transfer request, I release The Center for Advanced Pediatrics from any further medical responsibility for my children. I understand that I will be charged a fee of $20 per disc as allowed by the State of Connecticut unless Medicaid rules apply. If my annual administrative fee is up to date, I will receive a disc at no charge. I also understand that I am responsible for picking up these records and /or downloading them from the portal. I further understand that, in order to ensure compliance with applicable law, if I am requesting that the records be mailed to a third party (rather than picked up by me), I will be required to also sign a HIPPA authorization form. If downloading from the portal, a signed up to date HIPAA release must be on record.

Please note: The State of Connecticut privacy laws require that if certain information is included in the record of a minor 13 years of age or older they must sign the request form in addition to the parent or guardian. In order to ensure compliance, we ask all requests involving minors 13 years of age or older to sign this request form. Please note privacy information may be deleted at the discretion of your child's physician.

____
Parent/Guardian Signature Print Name/Date

____
Child 13 years or older Signature Print Name/Date

____
Child 13 years or older Signature Print Name/Date

You will receive a call from our medical records request transfer/ medical records coordinator when your records are ready.

_____ Request CD Disc @ $20 ____ Request CD Disc/Admin Fee Up to Date

Best number to reach me at to notify records are ready: ____________________

OFFICE USE ONLY: Received/recorded at TCFAP:___/___/___ by:____________ Fee Paid: Y N Date: ___/___/___
ADMIN FEE up to date: Y N Notified Ready: Y N Date: ___/___/___ Picked up/Sent: Date: ___/___/___

Rev 10.23.17