BLACK ROCK PEDIATRICS

RELEASE FORM

PATIENT RELEASE FORM	
Patient Name(s)	Date of Birth:

I hereby authorize the release of medical records for the above named patient/patients from:

(prior medical practice): _____

To: Black Rock Pediatrics
1817 Black Rock Turnpike, Suite 206, Fairfield CT 06825
Telephone: 203-337-5333

AUTHORIZATION		
Signature of Patient or Legal Guardian:	If Legal Guardian, specify relationship:	Date: