Pediatric Advanced Care of West Haven LLC
755 Campbell Avenue Suite 2
West Haven, CT 06516
203-889-2297
FAX – 203-889-2249

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date:_____ Patient name:_____

DOB:_____ Patient Address:_____

I request and authorize:_____

Fax number:_____

To release healthcare information on the patient named above to:

PEDIATRIC ADVANCED CARE OF WEST HAVEN – 755 CAMPBELL AVE, SUITE 2 – WEST HAVEN, CT

This request and authorization applies to: (Please check all that apply):

_____ Healthcare information relating to the following treatment, condition or dates:_____

_____ All Healthcare information

_____ Other

Patient/Parent/Guardian Signature:_____ Date:_____

This authorization expires 12 months after the date of signature above.

Confidentiality note: the information contained in this facsimile message is confidential and intended for the use of the individual named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination or copy of this fax is strictly prohibited. If you have received this fax in error, immediately notify the sender at the telephone provided above and return to us at the address listed above. Thank you.