1 Forest Park Drive
Farmington, CT 06032
860-677-1112

REQUEST OR TRANSFER OF MEDICAL RECORDS from Farmington Pediatric and Adolescent Medicine

PATIENT NAME: _____ DOB: _____ Last Visit :_____
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PATIENT 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)
_____
_____
____ Insurance Change (Name of main insurance) _____
____ Adulthood (Name of new Physician/practice)_____
____ Other: _____

By completing and signing this medical records/transfer request, I release Farmington Pediatric and Adolescent Medicine from any further medical responsibility for my children. I understand that Farmington Pediatric & Adolescent Medicine will send free of charge, copies of: Immunization history; most recent well-care exam; growth charts; allergy, medication & problem lists. If any additional items are requested to be copied, I will be charged a fee of $0.65 per page as allowed by the State of Connecticut unless Medicaid rules apply. 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

Please note that, per CT Statute, provider is allowed thirty calendar days to prepare these records. You will receive a call from our medical records coordinator when your records are ready.

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

OFFICE USE ONLY: Received/recorded at FPAM:___/___/___ by:_____
Fee Paid: Y N Date: ___/___/___
Notified Ready: Y N Date: ___/___/___
Picked up/Sent: Date: ___/___/___