Release of Medical Information

Partners in Pediatrics
95 Pitman St., Suite 2200
Providence, RI 02906
phone 401-437-6777 fax 401-437-6814

Please release the following medical records:

Name of patient: _____ DOB:_____
Address: _____
City: _____ State: ____ Zip Code: _____
Phone: _____

Please release the following:
___all medical records *
___last 2 years of records plus vaccination record
___vaccination record
___other (please specify type or dates): _____

*please note this may include outside correspondences such as mental health reports

Release from: _____
_____
_____
Release to:
____Partners in Pediatrics
____other (name and address):
_____
_____
_____
Comments/Reason for request:
_____

Signature of Adult:_____
Printed name:_____
Relationship to patient:_____ Date:_____

This release is valid for 1 year from the date signed, and may be revoked in writing at any time.