



BROOKSIDE PEDIATRICS
4637 MAIN STREET
SUITE 4
BRIDGEPORT, CONNECTICUT 06606
TELEPHONE: 203-374-3001
FAX: 203-372-6710

PATIENT RECORD RELEASE REQUEST

RELEASE OF MEDICAL RECORDS TO: BROOKSIDE PEDIATRICS

PARENT/GUARDIAN (PRINTED NAME): _____ TODAY'S DATE: _____

PATIENT: _____ D.O.B _____

PATIENT: _____ D.O.B _____

PATIENT: _____ D.O.B _____

PATIENT: _____ D.O.B _____

I HEREBY AUTHORIZE AND REQUEST THAT YOUR PRACTICE RELEASE ALL MEDICAL RECORDS CONCERNING MY
CHILD/CHILDREN -

TO: BROOKSIDE PEDIATRICS FROM BROOKSIDE PEDIATRICS

PARENT'S SIGNATURE: _____

IF TRANSFERRING FROM BROOKSIDE PEDIATRICS, TO ANOTHER FACILITY, PLEASE COMPLETE THIS SECTION BELOW
FOR THE LISTED CHILDREN ABOVE.

PLEASE RELEASE MEDICAL RECORDS TO THE FOLLOWING DOCTOR/FACILITY

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____