1672 South County Trail • Suite 201 • East Greenwich • Rhode Island • 02818
Phone 401 886-7881 • Fax 401 886-7883

Authorization to Release Medical Information

Patient Name ____ DOB ___/___/______

Address____

City ______________________________ State __________ Zip Code __________

I hereby authorize the release of copies of my medical records to:

Name: ____

Address:____

____

Phone: (   )_______-__________   Fax: (   )_______-__________

Records to be released from:
Ocean State Pediatrics
1672 South County Trail, Suite 201
East Greenwich, RI 02818

Records to be released via:

Fax ______   Encrypted PDF CD_____   Mail_____   Pick Up_____
***Please note: There will be a $15.00 fee for printed copies of records to be mailed or picked up.**

The reason for transfer of records: ______________________________________ .

I request the following information to be release:

Child's Well Visit(s) _____   Child's Office Note(s)_____   Child's Labs and/or Imaging_____

Entire Chart_____   Other____

__________________________   __________________________   ____/____/______
Signature of parent/legal guardian   Relationship to Patient   Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.