

RECORD RELEASE FORM

I, \_\_\_\_\_, give  
permission for the medical records of the patient(s) listed below to be  
transferred to the office of Dr. Thomas Binder at:

Hartford Area Pediatrics  
43 West Main Street  
Avon, CT 06001  
ph. (860) 678-9400  
fax (860) 678-9480

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_