

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 _____