Ocean State Pediatrics

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: ____/____/_____

Street Address _____

City _____ State _____ Zip Code _____ Phone: (_____)_____-_____

**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 USB _____ Print Copy _____

Mail _____ Pick Up _____

*****Please note: There will be a $35.00 fee per child for any printed copies of records.*****

---

*Are you transferring to a new provider? YES / NO*

If NO, reason for request: _____

I request the following information to be released:

Entire Chart _____ Last Two Years Medical History _____

Other (Please Specify) _____

_____ _____ ____/____/_____

Signature Relationship to Patient Date

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.**

Deborah Zinck, MD • Anne Noel, MD • Howard Silversmith, MD • Lisa Haines, MD • Christine Willis, MD
Leonora First, MD • Elizabeth Butler, MD • Michele Mathieu, MD • Danielle Cirillo, MD • Sarah Lake, MD