



# English Road Pediatrics & Adolescent Medicine, LLC

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## CONSENT TO RELEASE MEDICAL RECORDS

I authorize English Road Pediatrics to:

- Send** My Medical Records to:
- Obtain** My Medical Records from:

Physician Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize the release of the following information and / or medical records, if such information exists:

- Send all information**
- Treatment Plans
- Operation Report
- Progress Notes
- History & Physical
- Psychiatric Information
- Educational Information
- Medical Information
- Assessments
- Discharge Summary
- Lab Test Results
- Immunizations
- Other: \_\_\_\_\_

This authorization covers treatment period(s) : (Please select "all episodes" or indicate specific treatments, not both).

- From \_\_\_\_\_ to \_\_\_\_\_
- From \_\_\_\_\_ to \_\_\_\_\_
- From \_\_\_\_\_ to \_\_\_\_\_
- All episodes of care

I am transferring care to Dr: \_\_\_\_\_  
Reason: \_\_\_\_\_

- I am not transferring my care
- Share Information
- Legal Service
- Insurance

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: M / F

Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_ ; Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ ; Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*This release expires one year from the date above unless otherwise stated.**