Pediatric Medicine
52 Timber Lane
South Burlington, VT 05403

Phone: 802-658-2320
Fax: 802-863-6933
Email: Info@pedimedvt.com

RECORDS RELEASE AUTHORIZATION: Transfer from Pediatric Medicine

I, _____ hereby authorize the transfer of
(print name of parent/guardian or legal age patient)
medical records to:

Provider: _____

Address: _____

_____

Phone: _____

Fax: _____

Patient Name: _____ D.O.B._____

Patient Name: _____ D.O.B._____

Patient Name: _____ D.O.B._____

Guardian/Patient Contact Information: Phone: _____E Mail:_____

Address: _____

_____

Reason for request: □ Moving: Date needed by: _____

□ Transfer due to age

□ Other: _____

Records to be: □ Mailed □ Faxed □ Collected by patient or legally authorized representative.

Please note:

- Records will be released to the provided provider's office, parent, guardian or legal age patient.
- Picture identification may be required.
- If the patient is 18 years or older, the patient must sign this release.
- There may be a fee for copying this medical record for transfer.

_____ _____
Parent/Guardian or Legal age Patient Signature Date

If signing for a minor: □Parent of Minor □Legal Guardian □Other:_____