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 TO Pediatric Medicine

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

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: ____

____

<u>Records should be mailed or faxed to</u>:
Pediatric Medicine
52 Timber Lane
South Burlington, VT 05403
Phone:802-658-2320
Fax: 802-863-6933

____ ________________________
Parent/Guardian Signature Date

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