Pediatric Medicine
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South Burlington, VT 05403

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RELEASE TO SHARE RECORDS and INFORMATION

I, _____hereby authorize the exchange or release of information as indicated below:
(print name of parent/guardian or legal age patient)

Release to SHARE records and information between Pediatric Medicine and:

□ Provider : Name: _____

Address: _____

_____

Phone: _____

□ Parent □ Guardian □ Other: please define _____

Name: _____

Relation: _____

Patient Name: _____ D.O.B.: _____

Phone: _____ Email: _____

Address: _____

_____

If signing for a minor: Parent/Guardian Contact Information:

Name: _____

Phone: _____

I understand:

- The recipient authorized to receive my information may not be required to protect my information and may share my records without my permission.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at Pediatric Medicine.
- This release is valid from date of signature forward.
- I may revoke this authorization at any time by providing written notice to Pediatric Medicine. My revocation will not apply to the information that has already been released in response to this authorization.

_____ _____
Parent/Guardian or Legal age Patient Date

If signing for a minor: __Parent of Minor __Legal Guardian __Other