Pediatric Medicine
52 Timber Lane
South Burlington, VT 05403

Phone: 802-658-2320
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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._____

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

I give Pediatric Medicine permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions. Date range of records to be released: ___ /___ /___ to ___/___/___. (If no dates are specified, all records of this type will be shared.)
Or

☐ Disclose my complete health records **to include** the following information (please initial each to be included):

___ Mental health records
___ Sexually transmitted disease records
___ Confidential HIV/AIDS information
___ Alcohol/drug abuse treatment records
___ Genetic information
___ Other (Specify)_____

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.
- This authorization will expire on _____. If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.

_____ _____
Parent/Guardian or Legal age Patient Signature Date

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

Revised 4/23/25