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 medical records to:
(print name of parent/guardian or legal age patient)

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South Burlington, VT 05403
P: 802-658-2320 F: 802-863-6933
Email: info@pedimedvt.com

Patient Name: _____ D.O.B._____

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

I give _____, at _____permission to:
(name of medical practice) (address of medical practice)

☐ 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: _____

Please note:

- If the patient is 18 years or older, the patient must sign this release.
- 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:_____