51 Timber Lane, South Burlington VT 05403-5201

1127 North Avenue, Ste. 1, Burlington VT 0508

11 Haydenberry Drive, Ste. 103, Milton VT 05468

primarycare HEALTH PARTNERS

South Burlington: P: 802-864-0521 F: 802-735-9621

Burlington: P: 802-846-8100 F: 802-735-9337

Milton: P: 802-893-1200 F: 802-735-9608

TIMBER LANE PEDIATRICS
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize PRIMARY CARE HEALTH PARTNERS to release medical information as described below:

PATIENT NAME: _____ BIRTH DATE: _____ PHONE #:_____

PATIENT STREET ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

I hereby authorize records to be released to:

Name (Practice or Person) :
_____

Street Address: _____
City:_____

State: _____ Zip: _____ Phone #: ( ) _____ Fax #: ( ) _____

For the purpose of:

☐ Transfer of care out of practice ☐Disability/SSI
☐Insurance ☐School/Camp
☐Other (please specify): _____
_____

Reason for leaving:

☐Moving ☐Transitioning to adult practice
☐Dissatisfied ☐Transitioning to Naturopath
☐Other (please specify):

I authorize my medical information to be released for the following time period (choose one):

☐All Past, Present, and Future Dates
☐Specific Date Range _____ to _____

I authorize the release of (choose one):

☐My complete health record (including records relating to Mental Healthcare, HIV or AIDS, and treatment of alcohol or drug abuse
☐ My complete health record **with the exception of** the following information: ☐ Mental Health ☐HIV or AIDS ☐Drug/Alcohol
(Note: if you choose an exception, we may need to schedule time to discuss your request.)

★ Complete **ONLY IF** requesting records be given directly to you: ★

I request the medical information be distributed using the following means:

☐Patient Portal ☐Paper Sent by Fax ☐Paper Sent by Mail ☐Paper (will pick-up)
☐Other: _____

By signing this release, I understand that:

- Requests may be subject to fees at rates pursuant to State regulations (e.g. paper copies, CD/USB downloads).
- I may revoke this authorization by notifying the health center in writing.
- Unless otherwise revoked, this authorization will expire 1 year from the Consent date as signed below.
- Information used or disclosed pursuant to the authorization may be subjected to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____	_____
Patient Signature (18 years or older)	Consent Date
_____	_____
Parent, Guardian, Legal Representative Signature	Consent Date