

TIMBER LANEPEDIATRICS

1127 North Ave Ste 1

Burlington VT

05408



51 Timber Lane

S Burlington VT

05403

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

11 Haydenberry Dr

Milton VT

I hereby authorize PRIMARY CARE HEALTH PARTNERS to release medical information as described below: 05468

Patient Name: _____ Patient Date of Birth: _____

Patient Street Address: _____

Patient City: _____ State: _____ ZIP: _____ Phone: _____

I hereby authorize records to be released to:

Name: _____

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
- Other (please specify) _____

I authorize my medical information to be released for the following time period:

All Past, Present, and Future Dates **OR** Specify Date Range _____ to _____

I authorize the release of:

My complete health record (including records relating to mental healthcare, HIV or AIDS, and treatment of alcohol or drug abuse)

****OR****

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 pickup)

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