



Authorization to Disclose Health Information

I, _____ hereby authorize Timber Lane Pediatrics Providers/staff to accept information from and to give information to the below listed person/agencies/schools, for the purpose of providing evaluation and/or treatment of services.

Regarding: _____ Date of Birth: _____

Please check (all that apply): Medical Educational Social Mental Health Records
 Screening Services

Means of Disclosure (check all that apply): Written Oral Electronic

Provider/Agency/School _____

Address and Phone Number _____

Provider/Agency/School _____

Address and Phone Number _____

Provider/Agency/School _____

Address and Phone Number _____

Signature: _____ Date: _____

Printed Name: _____

I may revoke this authorization in writing at any time.

Timber Lane Pediatrics
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So. Burlington, VT 05403
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Timber Lane Pediatrics
1127 North Ave, Ste 1
Burlington, VT 05401
(P) 846-8100 (F) 735-9337

Timber Lane Pediatrics
11 Haydenberry Dr Ste 103
Milton, VT 05468
(P) 893-1200 (F) 735-9608