hagan
rinehart
connolly
pediatricians P.L.L.C.

Joseph F. Hagan, Jr., M.D., F.A.A.P.
Jill S. Rinehart, M.D., F.A.A.P.
Gregory J. Connolly, M.D., F.A.A.P.
Maryann Lisak, M.S.N., A.P.R.N., C.P.N.P.
Ashley Boyd, M.S.N., A.P.R.N., C.P.N.P.
Kelly Brush Davisson, M.S.N., A.P.R.N., C.F.N.P.
Kimberlee M. Roy, Ph.D.

Authorization for Disclosure of Health Information

Patient Name:______________________________ Date of Birth:________________

Patient Name:______________________________ Date of Birth:________________

Patient Name:______________________________ Date of Birth:________________

1). I authorize the use of disclosure of the above named individual's health information as described below.

2).The following individual or organization is authorized to make the disclosure:

Hagan, Rinehart & Connolly Pediatricians
128 Lakeside Ave. Suite #115
Burlington, VT 05401-4939

Today's date:________________ Date needed by:________________

we require at least 7-10 business days notice

3).The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

__________Complete health records
__________Physical exam
__________Immunization record
__________Lab results/x-ray reports
__________Consultation reports
_____Other (please specify):______________________________

4). I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse.

5). This information may be **disclosed to** and used by the following individual or organization for the purpose of medical treatment or consultation, billing or claims payment, or other purposes as I may direct:

Name:______________________________
Address:______________________________
City:____________________ State:____________ Zip:____________

6). I understand that I have a right to revoke this authorization in writing at any time. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7). This authorization will expire on the following date, event, or condition:______________________

8). I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

9). I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____
Signature of patient or legal representative

____
Printed name of legal representative

____
Date