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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:

**Lakeside Pediatrics**  
**128 Lakeside Ave. Suite 115**  
**Burlington, VT 05401-4939**

Today's date: \_\_\_\_\_ Date need by: \_\_\_\_\_

\*We require at least 10-14 business days notice\*

\*We do not fax records over 20 pages\*

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

\_\_\_\_\_ Complete health records    \_\_\_\_\_ Lab results/radiology reports    \_\_\_\_\_ Physical exam  
\_\_\_\_\_ Immunization record    \_\_\_\_\_ 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 (HPV). 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). Reason for transfer: \_\_\_\_\_

7). 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.

8). This authorization will expire on the following date, event or condition: \_\_\_\_\_

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

10). 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

*Please complete form in its entirety as it may cause a delay in sending the records.*