Lakeside pediatrics

Authorization for Disclosure of Health Information

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.