**Pediatric Medicine**
**52 Timber Lane**
**South Burlington, VT 05403**
**802-658-2320 phone**
**802-863-6933 fax**

# RECORDS RELEASE AUTHORIZATION

I, _____hereby authorize
(print name of parent/guardian or legal age patient)
the exchange/release of information as indicated below.

☐ Transfer records from Pediatric Medicine : **OR** ☐ Release to share records from Pediatric Medicine to Provider: _____
_____
_____
_____

OR Transfer records to Pediatric Medicine from:
Current Provider _____
_____
_____
_____

Patient Name:_____D.O.B._____

Patient Name:_____D.O.B._____

Patient Name:_____D.O.B._____

Guardian/Patient Contact Information: Phone:_____ E Mail:_____

Address: _____
_____
_____

Please indicate reason for request:
_____ Moving _____Transfer due to age _____ Other _____
If moving, please indicate date needed by:_____

Please note:

- Records will be released to **parent, guardian or legal age patient**. If patient is 18 years or older, the patient needs to sign this release.
- Picture identification may be required
- There is a fee for copying this medical record for transfer.

_____ _____
Parent/Guardian or Patient Signature Date

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It is our office policy to deliver records to the parent, guardian or legal age patient. Frequently we receive 2nd and 3rd requests for records delivered to another provider office. Therefore, we recommend you make an additional copy of these records, provide your new physician with a set and retain a set for your files.

The fee for this copy is $ _____

| | |
|---|---|
| # pages @ $ .50 each | |
| Postage | |
| Labor cost of copying | |
| Total charges | |

We will accept payment in cash, check or credit card
MasterCard ☐ Visa☐ Discover☐

Card #_____ Exp. Date:_____