

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME _____ DATE OF BIRTH ____/____/____

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[_____] **Records TO UVP, PLLC:** I hereby authorize _____
_____ [provide address if known
and/or Phone # _____ Fax # _____] to disclose to Upper Valley
Pediatrics, PLLC at 331 Upper Plain, Bradford, VT 05033 phone 802-222-4722 / fax 802-222-4709 the
specific information indicated below and for the purpose(s) indicated below.

[_____] **Records FROM UVP, PLLC:** I hereby authorize Upper Valley Pediatrics to disclose the
information indicated below and for the purpose(s) indicated below TO: _____

[provide address if known and/or Phone # _____ Fax # _____]

Federal Law protects certain sensitive information from release without specific authorization. I hereby consent
to the release of records related to the following indicated, by means of written &/or oral disclosure:

****PLEASE INCLUDE:** (records released FROM UVP will include the following)

(1) Immunization Record(s)

(2) Health Information Summary which includes a problem list, allergies, medication
history, immunization history, laboratory reports and any screening studies done

(3) Growth Charts – height or length, weight & BMI

**(4) If the patient is on any mental health or psychotropic medications, a copy of the most
recent medication check visit.**

This information is being requested for the following purpose(s):

_____ **Patient Transferring Care** _____ Appointment/Service Planning & Coordination
_____ Legal/Court Case Purposes

- I understand that it is the policy of Upper Valley Pediatrics to transfer records to another Primary Care Physician one time at no charge, additional requests for copies from other entities will be assessed a minimum fee of \$15.00.
- I understand that Drug & Alcohol Information as well as AIDS/HIV information may be disclosed if it is contained in my record. I understand that I have the right to restrict this information should I choose.
- I understand that federal regulations (42 CRF part 2) prohibit the disclosure of drug & alcohol treatment information without my written consent or as allowed by the regulations I understand that under Vermont statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule (Privacy Standards of the Health Insurance Portability and Accountability Act of 1996).
- I understand that my treatment/support is not conditioned upon authorizing this disclosure. I understand I may revoke this authorization at any time except to the extent that any agency making the disclosure, has already acted in reliance on it. In general revocation of this authorization should be submitted in writing to the entities indicated. This authorization remains in effect for one year from date below, unless otherwise indicated here: effective _____(DATE) through _____(DATE)

Printed Name _____ Relationship to Patient(s) _____

Signature _____ Date _____