

**CHAMPLAIN
OBSTETRICS & GYNECOLOGY**
55 Main Street, Suite 3, Essex Jct., VT 05452
Phone (802)879-1802 Fax (802)878-6131

Authorization for Release of Medical Records

I hereby authorize the release of my medical records:

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Daytime Phone #: _____

Information Released To:	From:
_____	_____
_____	_____
_____	_____

Please Release the Following:

<input type="checkbox"/> All Records	<input type="checkbox"/> Records for time period of _____ to _____
<input type="checkbox"/> Office Notes	<input type="checkbox"/> Lab Reports/Radiology Reports/Pathology Reports
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Pregnancy Related Office Visits
<input type="checkbox"/> Other (Specify) _____	

Including Information (if applicable) Pertaining to (including screenings):

Drug/Alcohol HIV/AIDS Genetics Testing

Purpose of Need for Disclosure:

<input type="checkbox"/> Transfer of Patient Care	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Continued Patient Care	<input type="checkbox"/> Insurance Claim/Application
<input type="checkbox"/> Attorney/Legal	<input type="checkbox"/> Other

I understand that I may revoke this authorization at any time by notifying Champlain OB & GYN, P.C. in writing, and it will be effective on the date notified except to the extent that Champlain OB & GYN, P.C. has already acted upon such Authorization. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. I may not hold Champlain OB & GYN, P.C. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ Signature of Patient or Legal Guardian	_____ Date
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_____ Signature of Other Parent (if patient is a minor)	_____ Witness
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Date Request Completed: _____ # Pages Copied _____ Initials _____