Essex Pediatrics
89 Main Street
Essex Junction, VT
(802) 879-6556 Phone
(802) 872-8021 Fax

(Patient Name) _____

(DOB) _____

(Form D2 Revised 05/14/18)

Authorization to Disclose Medical Information to Parents/Guardians (for patients >18yrs)

I give permission to Essex Pediatrics to speak with my parents/guardians and discuss general information from my medical record for the purposes of continuation of treatment:

(Parent Name) _____

(Parent Phone) _____

(Alternate Phone) _____

(Parent Name) _____

(Parent Phone) _____

(Alternate Phone) _____

This permission includes office notes, medication lists, laboratory/radiology reports, problem lists, immunizations, specialty reports, hospital admissions, and emergency room reports.

The following medical records have special protections. We need your specific permission to discuss the records listed below (initial all that apply):

☐ Mental health records _____ *(initial)*
☐ HIV/AIDS records _____ *(initial)*
☐ Alcohol/drug treatment records _____ *(initial)*
☐ Sexual abuse/assault and domestic violence records _____ *(initial)*
☐ Sexually-transmitted disease records _____ *(initial)*

I understand that:

- The recipient authorized to receive my information may not be required to protect my information and may share my records without my permission.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at Essex Pediatrics.
- I may cancel this authorization at any time by providing **written notice** to Privacy Officers, Sue Rogers-Low or Jill Kenneson at 89 Main St, Essex Junction, Vermont, 05452. My revocation will not apply to the information that has already been released in response to this authorization.
- I may inspect or copy any information to be used or disclosed under this authorization.
- **Unless otherwise cancelled in writing, this authorization will automatically expire one year from the date I sign below.**

Signature: _____ Date: _____ Time: _____
(Patient)