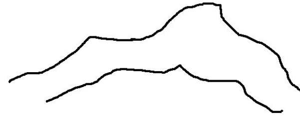

RICHMOND PEDIATRIC
AND ADOLESCENT MEDICINE
12 Burnett Court
Richmond, Vermont 05477
Telephone: (802) 434-5090
Fax: (802) 329-2144

Paul J. Parker, M.D., M.P.H.
Alyssa K. Parker, M.D.
Helen Schottel, M.D.

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Full Name: ____

Date of Birth: ______________________________________

I authorize the following organization to share and disclose protected health information for the purpose of coordination of care:

Richmond Pediatric & Adolescent Medicine
12 Burnett Court
Richmond, VT 05477

Please include the following information:

Complete copy of medical record: ________________________________
List any information to be excluded: ______________________________

This information may be shared with:

____

____

____

I understand that this authorization will expire without my express revocation, one year from the date written below. I understand that I have the right to request and inspect a copy of information to be disclosed and that I may withdraw this authorization at any time.

______________________	____
Date	Signature of individual or representative
	____
	Authority or relationship of representative