Lake Champlain
Gynecologic Oncology

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## Authorization to Release Protected Health Information

Patient Name:_____ Date of Birth: _____

This form authorizes Lake Champlain Gynecologic Oncology, P.C,

To Release information to:

Facility:_____

_____

Provider:_____

_____

Address:_____

_____

Phone:_____ Fax:_____

I hereby authorize Lake Champlain Gynecologic Oncology to release a complete copy of my medical records related to my medical diagnosis, treatment and condition. I authorize records of my treatment including drug, alcohol, depression, HIV/AIDS, hepatitis or other sexually transmitted disease unless specified below.

I do not want the following information released:_____

I understand that I have the right to inspect a copy of information to be disclosed and that I may withdraw this authorization at any time, except to the extent that action has been taken based on this authorization.

_____

I understand that this authorization will expire, without my express revocation, one year from the date signed.

Lake Champlain Gynecologic Oncology will impose a copying fee of $0.50 per page or a minimum of $5.00, whichever is greater.

Authorized Signature:_____ Date:_____

Address:_____ Phone:_____

City, State, Zip:_____