Authorization to Release or Obtain Protected Health Information

Patient Name: ___________________________________ Date of Birth: ________________

This release will authorize Lake Champlain Gynecologic Oncology, P.C. ,

☐ To Obtain from: ____

☐ To Release to: ____

A complete copy of my medical records related to my medical diagnosis, treatment, and condition.

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 hereby authorize Lake Champlain Gynecologic Oncology to release/obtain 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/obtained: ______________________________

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

Please mail or fax the records to the address listed below:

Lake Champlain Gynecologic Oncology
364 Dorset Street, Suite2
South Burlington, VT 05403
Phone: (802) 859-9500 Fax: (802) 859-9944

____ ________________________
Signature of Patient Date

____ ________________________
Street address Phone number

____
City, State, Zip code