Lake Champlain
Gynecologic Oncology

Gamal Eltabbakh, MD, FRCOG, FACOG • 1060 Hinesburg Rd, Ste 301, South Burlington, VT 05403

Authorization to Obtain Protected Health Information

Patient Name: _____ Date of Birth: _____

This form authorizes: _____

To release information to:

Lake Champlain Gynecologic Oncology
1060 Hinesburg Rd, Suite 301
So Burlington, Vermont 05403
P. 802-859-9500 F. 802-859-9944

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 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: _____

_____

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

Authorized Signature: _____ Date: _____

Address: _____ Phone: _____

City, State, Zip: _____

Lake Champlain Gynecologic Oncology

Gamal Eltabbakh, MD, FRCOG, FACOG • 1060 Hinesburg Rd South Burlington, VT 05403

Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____

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

To release information 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 records of my treatment, including drug, alcohol, depression, HIV/AIDS, hepatitis or other sexually transmitted disease unless specified below.

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

Authorized Signature: _____ Date: _____

Address: _____ Phone: _____

City, State, Zip: _____