



# Lake Champlain Gynecologic Oncology

Gamal Eltabbakh, MD, FRCOG, FACOG • 364 Dorset Street, Ste 2, 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.

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.

**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: \_\_\_\_\_



# Lake Champlain Gynecologic Oncology

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## Authorization to Obtain Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This form authorizes: \_\_\_\_\_

To release information to:

Lake Champlain Gynecologic Oncology  
364 Dorset St., Suite 2  
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: \_\_\_\_\_