Rainbow Pediatrics
44 Collins Drive, Suite 202, Middlebury, VT 05753
Phone: 802-388-1338 Fax: 802-388-8244
Medical Records Contact: Judith Walker

AUTHORIZATION for the RELEASE of PROTECTED HEALTH INFORMATION

Patient Name _____ Birth Date _____

Address _____ Phone (_____)_____

I hereby authorize Rainbow Pediatrics to:

❑ Release health information to:
(If you are transferring **from RAINBOW** to another provider)

❑ Receive health information from:
(If you are **new to RAINBOW** needing records from your previous provider)

Practice/Physician _____

Address _____

Phone Number (_____) _____ Fax Number (_____) _____

Reason for requesting this information:

❑ Transfer to adult/family practice
❑ Transfer due to change of insurance
❑ Transfer, moved out of area
❑ Other, please specify_____

The information to be released by Rainbow Pediatrics shall be all pertinent records and will be released to the above-named practice/physician by mail or courier (when applicable).

⏩The information released will include information relating to AIDS or HIV infection, treatment for substance and/or alcohol abuse or dependency, and psychotherapy notes or other information relating to mental health or psychiatric care. If you wish to EXCLUDE this information from the records being released, please initial here____

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Vermont Drug and Alcohol Abuse Control Act, the Vermont Mental Health Procedures Act, and/or the Vermont Confidentiality of HIV Related Information Act. My signature below authorizes the release of information protected by these Vermont statutes, unless initialed above.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Rainbow Pediatrics, its employees, officers and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from Rainbow Pediatrics upon request.

THIS AUTHORIZATION SHALL EXPIRE 90 DAYS FROM THE DATE BELOW, UNLESS OTHERWISE NOTED.

_____ _____ _____
Patient (18 years or older) or Parent/Guardian if patient is under age 18 | Date | Relationship to Patient