VERMONT DEPARTMENT OF HEALTH BOARD OF MEDICAL PRACTICE
108 Cherry Street - PO Box 70 Burlington, VT 05402-0070
Phone: 802-6574220 / Fax: 802-657-4227
Toll free within Vermont: 800-745-7371
E-mail: AHS.VDHMedicalBoard@vermont.gov

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE YOU to furnish to the Vermont Department of Health, Board of Medical Practice, and/or its designated representative, and to the Office of the Attorney General, all medical records and all information, without reservation, within your possession or control pertaining to my **child**, whether oral or written (including records provided to you by other health practitioners or health care institutions), relating to any physical, psychiatric, mental or emotional condition or injury or disease for which you may have been consulted or for which you may have provided services.

Only in regard to this specific authorization for disclosure to the Vermont Department of Health, Board of Medical Practice, and to the Office of the Attorney General, and for no other purpose, I hereby expressly WAIVE confidentiality and/or any privileges or immunities accorded this information by State or Federal law, including materials covered by 42 CFR, Part 2, and I hold you harmless from disclosure of same to the Vermont Department of Health, Board of Medical Practice, pursuant to my request, to evaluate certain aspects of my **child's** health care.

THIS AUTHORIZATION is subject to revocation at any time except to the extent that you have already taken action in reliance on it. If not previously revoked, this authorization will terminate upon final action, including a judicial determination, of any action taken by the Board of Medical Practice that is related to this information, or, if no such action is taken, will terminate 365 days from the date hereof.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Department of Health, Board of Medical Practice, or its designated representative, and to the Office of the Attorney General, on a continuing basis until this authorization expires or is revoked.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

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Child's Name (Print) Date of Birth

__________________________ ____________________________________
Parent/Guardian Name (Printed) Parent/Guardian (Signature) / Date

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Mailing Address