RECORDS RELEASE AUTHORIZATION

I_____ hereby request that _____

(Patient/Parent or Guardian) (Name of Releasing institution)

_____ _____

(Address) (Phone/Fax)

RELEASE THE FOLLOWING:
Outpatient Report From_____ To_____
Inpatient Summaries From_____ To_____
Operative Reports From_____ To_____
X-Ray Reports From_____ To_____
Laboratory Tests From_____To_____
Other _____ From_____ To_____

To:
Vermont Urogynecology Associates, P.C.
Mansfield Business Park
71 Knight Lane Suite #20
Williston VT, 05495
Phone (802)872-7001
Fax: (802)857-5588

_____

(Patient Name-Please Print)

_____

(Address)

_____

(DOB) (Phone)

_____

(Patient Signature) (Date)