Silver Lake Direct Primary Care

Authorization for the Release of the Medical Records of:

Patient Name:

Date of Birth:
Address:

I, the above named patient (or parent/legal guardian), hereby authorize and request that _____**(NAME OF HEALTH CARE PROVIDER),** release to Silver Lake Direct Primary Care, PLLC, my medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans. I understand that this authorization will expire when this request is fulfilled and that it may be revoked at any time in writing. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient or third parties and no longer protected by the HIPAA privacy rule.

I acknowledge that my records may include sensitive material. Therefore, I request that you include the following records, if any (initial by categories to be included in records provided):

___Substance Abuse ___AIDS/HIV/STDs ___Psychological/Psychiatric Conditions ___Genetic Testing

Please send the requested information to:

Phone: 802-775-3207 Fax: 802-775-3207

Silver Lake Direct Primary Care, PLLC
102A Court Street
Middlebury Vermont 05753

_____ _____
Signature Date

Relationship to patient: _____