GREEN MOUNTAIN PEDIATRICS

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Medical Record Restriction or Revocation Request

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➢ Restriction of Personal Health Information Request

I, _____, request that Green Mountain Pediatrics restrict the use or disclosure of the personal health information of my dependent,_____, including the following:

- ☐ Medical Records (treatment information & lab results)
- ☐ Billing Records
- ☐ Medical and Billing Records from a particular time period: _____
- ☐ Other (please describe below):

_____

_____

_____

Printed Name Signature Date

➢ Revocation of HIPAA Authorization

I, _____, revoke the consent for the use or disclosure of all protected health information of my dependent, _____.

This revocation will take effect on the date this form is received by Green Mountain Pediatrics, as confirmed by the recipient's signature below. I understand I can consent again at any time until my dependent turns 18, at which point their medical record will belong entirely to them.

_____

Printed Name Signature Date

_____

Recipient Printed Name Signature Date