Release to Share Records and Information

Patient Name _____ DOB _____ PCC# _____

I, _____ hereby authorize the exchange or release of
(print name of parent/guardian or legal age patient)
information as indicated below.

Release to share records and information between Upper Valley Pediatrics, PLL and:

☐ Provider Name:_____
Phone _____

☐ School Name _____
Phone _____

☐ Agency Name _____
Phone _____

I understand:

- The recipient authorized to receive my child's information may not be required to protect my information and may share my records without my permission.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at Upper Valley Pediatrics.
- This release is valid from the date of signature and forward
- I may revoke this authorization at any time by providing written notice to Upper Valley Pediatrics. My revocation will not apply to the information that has already been released in response to this authorization.

_____ _____

Signature of Parent/Guardian or Legal-age Patient Date

Revised 1/1/2026