Motor Vehicle Accident Insurance & Consent to Release Medical Records Form

Patient Information

Last Name *First* *Middle*	*Request Date*
Birth Date	*Date of Accident*
Mailing Address	*Were you the driver in the accident or passenger?* ☐ Driver ☐ Passenger
City/State/Zip	*Telephone #*

Vehicle Information *Your Signature allows Lamoille Health Partners to contact your insurance company.*

Insurance Name	*Insurance Telephone Number*
Name of vehicle owner	*Insurance Fax Number*
Insurance Mailing Address	*Adjuster's Name*
	Claim number

Information of other vehicle involved *Your Signature allows Lamoille Health Partners to contact this insurance company.*

Insurance Name	*Insurance Telephone Number*
Name of vehicle owner	*Insurance Fax Number*
Insurance Mailing Address	*Adjuster's Name*
	Claim Number

REQUIRED SIGNATURE

I authorize Lamoille Health Partners to provide all medical records and reports as requested by myself, my insurance, or the insurance listed above regarding the diagnosis, condition, or treatment related to this specific claim.

Signature of Patient _____ *Date* _____

For Questions: Please Contact Patient Financial Services at (802) 851-8600