Vermont Authorization for Release of Protected Health Information

Patient Name: ______________________________ **DOB:** ____/____/______
Last name *First name* *Middle initial*

Phone number: ____________________ **ID Number:** ______________________________

I ____________________ (name of patient or representative) authorize the release, use or disclosure of the above named patient's protected health information.

Provide information **To**:

____
Clinician Name/Organization

____
Phone Fax

Receive information **From**:

____
Street Address

____
City/State/Zip Code

The purpose(s) for which disclosure is authorized:

Sharing with other health care providers For patient's personal records

Other (please describe) ______________________________

I authorize release, use or disclosure of following information (check all that are applicable):

Entire record Immunizations CAPS note(s) Most recent general physical exam

All notes related to specific condition or issue (please specify): ______________________________

Specific visit/encounter note (please specify): ______________________________

Lab results (please specify): ______________________________

Imaging reports (please specify CT, MRI, X-Ray, etc.): ______________________________

Other (please describe): ______________________________

I understand that:

Released records may include information related to: mental health counseling and behavioral health notes/sexually transmitted diseases/genetic testing including test results/Acquired Immunodeficiency Syndrome (AIDS), or Human Immuno-deficiency Virus (HIV), including, but not limited to, test results and the fact that a test was taken/and protected by 42CFR Part II, federal laws protecting alcohol and drug abuse records.

The Following limitations may apply: ______________________________

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I have the right to receive a copy of this Authorization, and may revoke the same at any time by providing a written notice of revocation. However, such revocation would not affect any action taken by the recipient in reliance on this Authorization, before receipt of my written revocation. The information released/disclosed by this Authorization, except information protected by federal regulations about the confidentiality of drug and alcohol abuse records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. ***Authorization to release this information is valid for 12 months from the date of signature on this release.*** Fees may be assessed for a copy of protected health information provided to me directly.

______________________________/____________ ____________
Signature of patient or personal representative (e.g. legal guardian) / Relationship to patient Date

______________________________ ____________
Signature of witness: Date

For office use: Records requested or released by: ______________________ Date: ____________
(Medical Records Coordinator or other staff member)

Information sent via: ☐ Fax ____________ ☐ Mail ☐ Provided to patient on (date) ____________