THE University of Vermont HEALTH NETWORK

Central Vermont Medical Center
PO Box 547
Barre, VT 05641

MRN

Name

DOB

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

BY SIGNING THIS FORM, YOU AUTHORIZE THE CENTRAL VERMONT MEDICAL CENTER OR ITS AGENTS TO RELEASE OR OBTAIN YOUR HEALTH INFORMATION TO THE PARTIES LISTED IN SECTION C BELOW. PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY RELEASE.

Section A:

Patient Name:_____ **Date of Birth:**_____

Patient Address:_____**City:** _____

State & Zip Code:_____**Phone Number:** _____

Section B: Reason for Release of Information:

☐ Medical Care	☐ Personal Records	☐ Insurance/ Payment	☐ Workers' Compensation	☐ School:
☐ Attorney/Legal Proceedings	☐ Provider Transfer	☐ Disability	☐ Other:	

Section C: Party to Receive or Obtain Information:

☐ Release a copy of my protected health information (PHI) to:

☐ Obtain a copy of my PHI from:

Name:	
Address:	
Phone Number:	Fax Number:

Delivery Method : ☐Mail ☐Pick Up ☐ Secure portal (Please provide email address to receive link:
☐E-mail address: _____ **(only for patients, patient guardian(s), or next of kin for deceased patients).**

☐CD ☐Thumb drive ☐ Other: _____

Please note that if the request is for an unencrypted electronic delivery method, it may not be secure. The requester acknowledges and accepts risk associated with unencrypted electronic transmission. It is the recipient's responsibility to protect the information once received.

Section D: Description of the Information to be released:

The date of service and type(s) of information to be used or disclosed are as follows:

The records to be released will cover the time period from _____to_____

Records from a specific Provider/Clinic: _____

☐ Discharge Summary	☐ Emergency Dept. Notes	☐ Cardiology Testing Reports	☐ Billing
☐ Inpatient Notes	☐ Laboratory/Pathology Reports	☐ Radiology Reports	☐ Immunizations
☐ Office or Clinic Notes	☐ Operative Reports	☐ Radiology Images	☐ History and Physical
☐ Consults			

☐ Other: _____

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Section E:

For certain sensitive information, you must initial in the box below for the information to be included in your release.

SENSITIVE HEALTH INFORMATION This form authorizes Central Vermont Medical Center to release the following types of information, **ONLY IF** you place your initials in the space provided:

_____ Mental Health Records (including Psychotherapy) _____Confidential HIV/AIDS Information

_____ Sexually Transmitted disease (STI) records _____Genetic Testing Results

_____ Substance, Drug, Alcohol Use Disorder Records from a 42 CFR Part 2 program

- Certain alcohol/drug treatment information from a "Part 2 Program" must be accompanied by the required statement regarding prohibition of re-disclosure. (42 CFR Part 2)
- For New York sites: Confidential HIV/AIDS information must be accompanied by the required statements regarding prohibition of disclosure when required by law. Information from certain mental health clinical records may be released pursuant to this authorization to the parties identified, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

I understand and agree that:

- I may be charged a fee for copies in accordance with state and federal law. The fee schedule is available by contacting Health Information Management by **Phone: (802) 371-4213 or Fax: (802) 371-5351.**
- I can revoke (cancel) this authorization at any time by submitting my request in writing to the entity to whom I submitted this authorization form. My revocation will not apply to information that has already been released in reliance upon this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law, unless specific re-disclosure laws apply.
- Signing this form is voluntary. I do not need to sign this form to receive health care services from the organizations, affiliates, or entities within The University of Vermont Health Network.
- **This authorization will expire on _____. If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.**

When the patient is a minor or is not competent to provide authorization, the signature of a parent, legal guardian or other legal representative is required. If the patient is between the ages of 12-17, the patient will need to authorize the release of records for some services. Documentation of a legal representative's authority may be required to process this form.

_____ _____ _____
Signature of Patient Date Time

_____ _____ _____
Signature of Parent or Legal Representative Date Time

_____ _____
Print Name Relationship (if signed by Parent/Legal Representative)

FOR OFFICE USE ONLY		
I have authenticated the identity of the person named in this authorization form via ☐Photo ID ☐Other		
Employee Signature	**Date Received**	**Date Completed**