

Authorization to Disclose Protected Health Information

- BY SIGNING THIS FORM, YOU AUTHORIZE THE UNIVERSITY OF VERMONT MEDICAL CENTER AND ITS AGENTS TO RELEASE INFORMATION TO OR RECEIVE INFORMATION FROM THE PARTIES LISTED ON PAGE 2 OF THIS DOCUMENT.**
- YOU MUST COMPLETE ALL SECTIONS. IF ANY SECTION OF THIS FORM IS INCOMPLETE, THIS FORM MAY BE INVALID.**
- If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative (Health Care Agent or Legal Guardian) must sign and date the form AND attach supporting documentation.

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date this form.

If the patient is deceased, the "next of kin" or executor must sign and date the form AND attach supporting documentation.
- If the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, your request for information will be submitted for processing and delivered by mail.

I understand that:

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing, behavioral or mental health services, and treatment of alcohol or drug abuse.
- 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 at 802-847-2846, Monday-Friday 8:00 – 4:30.
- I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing addressed to: The University of Vermont Medical Center, Health Information Management, 111 Colchester Avenue, Burlington, VT 05401.
- My revocation will not apply to the information that has already been released in response to 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.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at The University of Vermont Medical Center.

Expiration of Authorization

I understand that this authorization will expire on _____ (insert expiration date). If I do not specify an expiration date, this authorization will expire 1 year from the date I signed the authorization.

(Signature of Patient/Legal Representative)

(Date)

(Print Name)

Relationship to Patient (if signed by Legal Representative)

For office use only: Identification verified by _____ Date _____



Authorization to Disclose Protected Health Information

Patient Address: _____

City: _____ State: _____ Zip Code _____ Phone# _____

I authorize The University of Vermont Medical Center to (please only check one per authorization):

Send information to:

Receive information from:

Name: _____ Phone #: _____

Address: _____

For the following purpose(s):

Current treatment

Personal Records

Insurance

Workers' Compensation

Attorney

Provider Transfer

Disability

Other: _____

Check all that apply:

Hospital Records

- Inpatient Admission
- Outpatient Surgeries
- Emergency Room
- Procedures
- Tests

Family Practice/Medicine

- Milton Family Practice
- South Burlington Family Practice
- Colchester Family Practice
- Hinesburg Family Practice
- Aesculapius
- Given Burlington
- Given Williston
- Given Essex
- Berlin Family Health

Specialty Clinics

- Pediatrics
- Hematology/Oncology
- Neurology
- Women's
- Neurosurgery

Specialty Clinics: please fill in clinic name in the "Other" field below if not listed above. (For example: Cardiology, Pain Management, Orthopedics, Endocrinology, Rheumatology, Dermatology, Ophthalmology, Continence Center, Urology, etc.)

Other: Child Psychiatry Services Tel: 802-847-2224 Fax: 802-847-7998

Check all that apply:

Hospital Record

- Hospital Abstract (includes any available documents below **OR** check only those documents needed)
- Discharge Summary
- History & Physical
- Consultation
- Operative Report
- Laboratory Results
- Cardiology Report
- ED Report
- Other:
- Pathology Report
- EKG Report
- Radiology Report

Physician Office Records

- Clinical Abstract (includes any available documents below **OR** check only those documents needed)
- Office Notes
- Medication Lists
- Laboratory/Radiology Reports
- Other: Psychotherapy
- Problem Lists
- Immunizations

Date of Care to be Released: _____ **to:** _____ (please specify dates)

(Signature of Patient)

(Date)

(Print Name)

Description of Authority to Act for Patient
(Documents Required)

