THE University of Vermont HEALTH NETWORK

Central Vermont Medical Center

Authorization to Release Patient Health Information

Need Assistance? Please call 802-371-4213.

Copying Fee for Releasing Records: $5.00 flat fee for first 10 pages plus $0.50 per page for each additional page. Copying fee is waived when releasing records directly to a healthcare facility, physician, or other practice.

Section A: Patient Information (Please print when writing.)

I, _____, give Central Vermont Medical Center (CVMC) permission to:

☐ **Release** medical records as I instruct below.

☐ **Obtain** medical records from another healthcare provider: _____

The Patient's Name: _____ **Date of Birth:** _____

Purpose of this release: _____

Person(s)/organization to receive the information: _____

Address: _____

Fax#: _____ Phone#: _____

The date of the treatment, or date range, you'd like to release. _____

Please check off the information you'd like to release.

___ The Test Results circled: laboratory, radiology, cardiology, respiratory, neurology ___ ALL Test Results

___ Hospital Physician Notes ___ Surgical Records ___ Hospital Nurses Notes ___ ALL Hospital Information

___ Emergency Department ___ Express Care ___ Rehab Services ___ Woodridge Records

___ Practice Notes from: _____ ___ ALL Practices

___ Radiology Film released on a CD (Contact Diagnostic Imaging (DI). Fee is $10.00. Phone: 802-371-4252 Fax: 802-371-4852)

___ Radiology Film released electronically. E-Mail: _____ (contact: xrayrelease@cvmc.org)

Other Documentation: _____

Section B: Special Authorization: This section must be completed to release this sensitive information.

Please initial each section you want to include in this authorization.

HIV or AIDS Status: _____ **Inpatient Psychiatry: _____** **Family Psychiatry Practice: _____**

Alcohol or Drug abuse or treatment (Federal Rule 42 CFR part 2)

___ All Alcohol/Drug Notes ___ Alcohol/Drug Attendance Only ___ Alcohol/Drug Treatment Plan Summary

Section C: Statement of Rights

I understand this authorization is voluntary. I understand that the person, or organization, I am giving permission to receive my information may re-release information, and that they may not be required by state or federal regulations to protect patient privacy. I understand my healthcare treatment and my healthcare bill will not be affected by this form. I understand that I may see the information I have described above, and I can receive a copy of the information upon my request. I understand I can revoke, or cancel, this authorization at any time by notifying Central Vermont Medical Center in writing. I also understand that revoking, or canceling, this authorization will not affect any release of information that had already occurred before I revoked this authorization. I understand this authorization will expire 1 year from the date of my signature.

Signature of Patient or Patient's Representative: _____ **Date**: _____

Printed Name of Patient's Representative: _____

Section D: For Office Use Only: I have authenticated the identity of the person named in this authorization form:

☐ Picture ID ☐ Other (specify) Employee Signature:

Forms Committee ID	HIM-050
Date Reviewed	Dec. 2015

(For Scanning) Acct# _____