Southwestern
Vermont Health Care

Authorization for Release of Information

Patient Name: _______________________________ Date of Birth: __________ MR#: __________
Print

Address: ____
Print

I hereby authorize SVHC the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. This authorization is valid for 1 year unless otherwise specified.

Name and Address of Persons/Organizations authorized to receive information:

____

____

Specific description of information that may be used/disclosed and dates of service:

- ☐ X-ray Films and Report
- ☐ Office Notes
- ☐ ER Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Outpatient Department
- ☐ Other: (Describe) ____

This authorization permits SVHC to disclose my protected health information from my health record with no limitations placed on history of illness, diagnostic or therapeutic information including any treatment for alcohol and drug abuse, psychiatric impairment, HIV/AIDS related illnesses or genetic testing.

The information will be used / disclosed for the following purpose(s):

- ☐ Requested by the patient and for the patient (not necessary to disclose purpose).
- ☐ Insurance claim
- ☐ Other: (Describe) ____

____

- ☐ I understand that this authorization is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to ensure healthcare treatment.
- ☐ I understand that I may inspect or copy the information used or disclosed.
- ☐ I understand that I may revoke this authorization at any time by notifying SVHC, in writing, except to the extent that:
  1. action has been taken in reliance on this authorization; or
  2. if this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

____ __________

Signature of Patient or Patient representative Date:

____

Relationship to patient, or representative's authority to act for the patient (if applicable).

Request Received: _______ Date Processed: ______
Date: Date:

☐ Copy of Authorization given to the individual

Initial of person finalizing request: _____

Created date: 4/14/03 Revised date: 5/5/03

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