COMMUNITY HEALTH SERVICES OF LAMOILLE VALLEY®

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT PROTECTED HEALTH INFORMATION

PATIENT INFORMATION	**Patient Name:** _____ Date Of Birth: _____ **Address:** _____ Telephone: _____ **City** _____ **State:** _____ **Zip:** _____ ☐ **MAIL RECORDS TO THIS ADDRESS**
CLINIC NAME ***Who* has the information you want released?** **Please list the specific clinic.**	**Name of Clinic/Person who will release:** _____ **Address:** _____ **Telephone:** _____ **City:** _____ **State** ____ **Zip:** _____
RECEIVING PARTY ***Where*** do you want the information sent? ***Who*** may have the information?	**Name of Clinic/Person who will receive:** _____ **Address:** _____ **Telephone:** _____ **City:** _____ **State** _____ **Zip:** _____ **Fax Number (URGENT PATIENT CARE BETWEEN PRACTITIONERS)** _____
INFORMATION TO BE DISCLOSED (***What*** do you want sent or released?) **Check the appropriate box**	**Date(s) of Information to be Disclosed: From** _____ **To** _____ **(month/year) (month/year)** **If left blank, information from the past two (2) years will be disclosed.** ☐ **Clinic Records (office visit, lab, radiology, medicines, immunizations)** ☐ **Billing Records** ☐ **Copies of Films/Images from Stowe Family Practice** ☐ **All Medical records related to (specify condition, treatment, etc.):** _____ ☐ **All Billing records related to (specify condition, treatment, etc.):** _____ ****Paper records from prior to 2006 (50 cents a page charge) Sign here to accept charge:** _____ **VT Statute 144.292 and Federal Rule 45 C.F. R. §164.524** **You Must Check Below for the Following Information to be Released/Disclosed** ☐ ****Alcohol/Drug Abuse Treatment** ☐ **HIV Test Results** ☐ **Mental Health Records**
Release Instructions ***How*** and ***When*** do you want the information?	**Date information is needed:** _____ **(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)** **Format requested: (check one)** **Release Method** ☐ **Paper** ☐ **Disk/CD** ☐ **Mail my Records** ☐ **Will be picking up at the clinic**
Purpose of Release (***Why*** is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Social security ☐ Insurance application * ☐ Personal use or review * ☐ Disability ☐ Insurance payment/claim determination ☐ Litigation/legal

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The CHSLV Health Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- CHSLV will not restrict my treatment if I choose not to sign this authorization. A photocopy/fax of this authorization will be treated in the same way as an original. CHSLV records may include records that it received from other organizations. If these records have been used by CHSLV and filed in the record CHSLV maintains about you, these records may be released with your CHSLV Health records.
- CHSLV cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release CHSLV from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.
- **** Notice Prohibition Redisclosure of Alcohol/Drug Abuse Treatment Record Release: This information has been disclosed to you from the records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2**

_____ **Patient/Legal Representative Signature**

__/__/__ **Date**

_____ **Print Name:**

Origin 07/20/2016
Form 500.332B

Legal Guardian/Executor/Power of Attorney Documentation on file or attach and scan

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Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for)

Clinic/Health care Provider: Identify which CHSLV clinic you are seeking information from (or to be sent to). **Please be specific** in your request. For example, Morrisville Family Health Care,

Receiving Party: Identify the full name/business, address, phone and contact information with the name of the individual who is *to receive* the information. Please note: It is CHSLV policy **NOT** to fax or email patient information except for direct patient care requirements (e.g. to a doctor or clinic). *Please allow 7-10 days for all requests to be processed and sent to the recipient*.

Information to Be Disclosed: This section gives us the instructions for what information you want released. If you leave the dates of information to be disclosed blank we will send you medical records from the prior two years. This is typically what doctors' offices, hospitals or other health care providers need to provide information related to your care. If you select "2006 to today your entire electronic healthcare record will be provided. If you want those records of care prior to 2006 there will be a charge of 50¢ per page or $5.00, whichever is higher. It is very helpful if you identify the date or range of dates, needed by the requestor. When you check the box to Disclose/Release

Mental Health Record Release: This includes medications, prescription and monitoring documentation, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. This release **DOES NOT** include the release of Psychotherapy Notes.

Release Instructions: This tells us what format and how you would like your medical record delivered. We can print the documents or create a CD and mail them or they can be picked up at the clinic.

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date or event. You may indicate the consent is valid "5 years", "10 years", but there needs to be an ending date. The authorization is revoked at your written direction to our organization.

Contact Information for Patient Record Fee Charges or for issues with difficulty with ability to pay this fee

Jennifer Clapp
Analytics & Informatics Director
802-253-9156

For a list of CHSLV locations and addresses, please visit www.chslv.org