Authorization to Release Patient Protected Health Information

I,___________________________________ Maiden Name (if applicable)____________________ Date of Birth____/______/______

Authorize:

Neurology Clinic
Name of Physician/Practice

607 Washington Highway
Address

Morrisville VT 05661
City State Zip Code

To Release/Disclose the Following Information:

☐ **Clinic Records (Office Visit Notes, Medications, Labs, Radiology, Consults)**

☐ **Billing Records**

☐ **Date(s) of Information to be Disclosed: From:__________________ To: ______________**
☐ **All Records from 2006-Today's Date** **(month/year)** **(month/year)**

If left blank, information from the past two (2) years will be disclosed

Paper records from prior to 2006 (50 cents a page charge) Initial here to accept charge:__________
VT Statute 144.292 and Federal Rule 45 C.F. R. §164.524

Please Release To:

____
Name of Physician/Practice

____
Address

____
City State Zip

Date information is needed: /_______/_______
(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)

Release Method:
☐ Mail my Records
☐ Will be picking up at the clinic

Format requested: (check one)
☐ Paper ☐ CD/Disk

Purpose of Patient Request:

☐ Patient Request ☐ Transfer of Care ☐ You May Also Discuss this Information with: ____________________

You Must Check Below for the Following Information to be Released/Disclosed

☐ ****Alcohol/Drug Abuse Treatment** ☐ **HIV Test Results, Diagnosis or Treatment** ☐ **Mental Health Records**
Except psychotherapy notes

This Authorization will expire in 12 months from the date of signing or until I cancel this authorization.
I may cancel this Authorization at any time during the above period by notifying (Physician/ Practice) in writing, and it will take effect on the day request is received, except where the records have already been released.
I am signing this form voluntarily, and am not required to do so to ensure health care treatment, payment, or eligibility for benefits. I understand that if the persons/organizations that receives the Health Information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations.
I understand that I may have a copy of this signed Authorization form if I ask for one, and that I have the right of access to inspect and obtain a copy of my protected health information. I understand a photo-static copy of this authorization shall be considered as valid as the original.
** **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**

Signature of Patient/Legal Representative:____ Date:______/____/___________

Printed Name of Patient/Legal Representative: ____

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