



**Directions for Completion of Form**

**YOU MUST COMPLETE ALL SECTIONS. IF ANY SECTION OF THIS FORM IS INCOMPLETE, THIS FORM MAY BE INVALID**

**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. It is CHSLV policy to fax or electronically send patient information for direct patient care to the provider. Please note: It is CHSLV policy **NOT** to fax or email patient information except for direct patient care requirements.

**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 for information related to your care.

**Payment of Fees for Copies.** You may be charged a fee for copies in accordance with state and federal law and CHSLV policy. The fee schedule is available by contacting Health Information Management at 802-888-5639, Monday-Friday 8:30 am to 4:30 pm.

**Release Instructions:** This tells us what format and how you would like your medical record delivered to you. We can print the documents or create a CD and mail them or they can be picked up at the clinic. Authorizations cannot be predated for action in the future. CHSLV must be able to act upon a release of information upon receipt of this Authorization.

**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).

**Who must sign:** 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.

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.

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**For a list of CHSLV locations and addresses, please visit [www.chslv.org](http://www.chslv.org)**