Vermont Gynecology
1775 Williston Rd., Ste. 110, So. Burlington, VT 05403
(802) 735-1252 Fax (802) 862-9637 info@vtgyn.com

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME (printed): _____ **DATE OF BIRTH**: _____

PATIENT ADDRESS: _____

PATIENT PHONE NUMBERS: **(Home)** _____ **(Mobile)** _____ **(Work)** _____

I authorize _____ to disclose my health information to Vermont Gynecology and request that _____ provide my medical record to Vermont Gynecology. (Unless I specify otherwise in writing below, I understand and intend that this authorization applies to information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), information about behavioral or mental health services, and treatment for alcohol or drug abuse.)

This Authorization is made at my request for the purpose of continuing care.

ACKNOWLEDGMENTS AND CONDITIONS

1. This Authorization will expire 12 months from the date of signing or until I cancel this authorization.
2. I may cancel this Authorization at any time during the above period by notifying the above practice in writing, and it will take effect on the day the request is received, except where the records have already been released.
3. I am signing this form voluntarily, and am not required to do so to ensure health care treatment, payment, or eligibility for benefits.
4. 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.
5. 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.

PATIENT SIGNATURE: _____ **DATE:** _____

If a personal representative signs on behalf of the patient (e.g. the patient is a minor or is an adult who has named a representative):

SIGNATURE OF PERSONAL REPRESENTATIVE: _____DATE:_____

PRINTED NAME OF REPRESENTATIVE: _____ RELATIONSHIP TO PATIENT: _____

Please return completed authorization to:
Vermont Gynecology, 1775 Williston Rd., Ste. 110, So. Burlington, VT 05403 Or Fax (802) 862-9637