AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH_____

I authorize the use and disclosure of my health information as described below:

Persons/organizations **providing** the information:	Persons/organizations **receiving** the information:
Vermont Women's Choice/Planned Parenthood	Vermont Gynecology, P.C.
23 Mansfield Avenue	P.O. Box 250
Burlington, VT 05401	Shelburne, VT 05482

☐ I give permission for the receiving persons/organizations to send health information back to the providing persons/organization.

I understand that that if I refuse to release all or some of my health information, it may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, or other insurance or other adverse consequences.
I specifically authorize release of the following information:

DATES:

Release the entire Medical Record, OR (check the appropriate box(s));

☐ **I DO** ☐ **I DO NOT** want information relating to HIV test results, status, or treatment released _____

☐ **I DO** ☐ **I DO NOT** want information relating to participation in an Alcohol or Drug Abuse Treatment Program released _____

☐ **I DO** ☐ **I DO NOT** want information relating to diagnosis or treatment of Mental Health released _____

☐Other conditions: _____

This Authorization is made for the following purpose:

☐ At my request

☐ Other:

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire 30 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 PPNNE/VWC in writing, and it will take effect on day the request is received, except where the records have already been released.
3. Not agreeing to or canceling this authorization may be basis for denial of health benefits or other insurance coverage or benefits, but is not a condition for medical treatment.
4. I understand that if the person/organization 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.

PATIENT SIGNATURE:_____ **DATE:** _____

SIGNATURE/ RELATIONSHIP OF PERSONAL REPRESENTATIVE OF PATIENT: _____

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____