Vermont Gynecology
Compassionate, Contemporary Care

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

***PLEASE NOTE: RECORDS SHOULD BE FAXED OR MAILED, WE DO NOT ACCEPT USBs/CDs UNLESS FOR IMAGING***

Patient Full Name: _____ DOB: _____

Current Address/City/State/Zip: _____

List any previous names: _____ Phone: _____

*I authorize the use and disclosure of my health information as described below, limit one form per provider/facility:*
*Check one box only:*

☐ I give Vermont Gynecology permission to **OBTAIN** my medical records **FROM**:
☐ I give Vermont Gynecology permission to **RELEASE** my medical records **TO**:

Facility/Provider Name: _____

Address/City/State/Zip: _____

Phone: _____ FAX: _____ Appt?/Date: _____

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**Reason for Transfer of Records:** ☐ coordination of care with a new PCP; ☐ coordination of care with an Obstetrics Provider; ☐ coordination of care with a Specialist; ☐ transfer of Gyn care to another facility/provider; ☐ other, list:_____

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☐ *I give permission for the receiving persons/organizations to send health information back to the providing persons/organizations (as in coordination of care).*

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***I would like to release the following information (check one):***

☐ Entire Medical Record, includes notes, labs, and imaging

☐ Most recent 2 years of Medical Record, from last date seen

☐ Notes only

☐ Other (list specific records and/or date range): _____

_____

☐ **Restrictions:** Do not release (specify records to exclude from release): _____

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## CONDITIONS OF AUTHORIZATION

*I understand 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 of other adverse consequences.
- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), genetic testing, behavioral or mental health services, and treatment of alcohol or drug abuse.
- I may be charged a fee for copies of records in accordance with state and federal law. There is no fee for records faxed directly to another provider.
- I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing, and that my revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at Vermont Gynecology.
- This **authorization will expire** on _____. If I do not specify an expiration date, this authorization will expire one year from the date of signature.

PATIENT SIGNATURE: _____ DATE: _____

SIGNATURE/RELATIONSHIP OF PERSONAL REPRESENTATIVE OF PATIENT: _____

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*FOR OFFICE USE ONLY: DATE REQUEST FILLED:* _____ *BY:* _____ v2022.08