

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

BY SIGNING THIS FORM, YOU AUTHORIZE THE UVM MEDICAL CENTER OR ITS AGENTS TO RELEASE OR OBTAIN YOUR HEALTH INFORMATION TO THE PARTIES LISTED IN SECTION C BELOW. PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY RELEASE.

Section A:
Patient Name: _____ **Date of Birth:** _____

Patient Address: _____ **City:** _____

State & Zip Code: _____ **Phone Number:** _____

Section B: Reason for Release of Information:

<input type="checkbox"/> Medical Care	<input type="checkbox"/> Personal Records	<input type="checkbox"/> Insurance/Payment	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> School:
<input type="checkbox"/> Attorney/Legal Proceedings	<input type="checkbox"/> Provider Transfer	<input type="checkbox"/> Disability	<input type="checkbox"/> Other:	

Section C: Party to Receive or Obtain Information From:

- Release a copy of my protected health information (PHI) to:
- Obtain a copy of my PHI from:

Name:	
Address:	
Phone Number:	Fax Number:
Delivery Method : <input type="checkbox"/> Mail <input type="checkbox"/> Secure portal (Please provide email address to receive link: <input type="checkbox"/> E-mail address: _____ (only for patients, patient guardian(s), or next of kin for deceased patients). <input type="checkbox"/> CD <input type="checkbox"/> Thumb drive <input type="checkbox"/> Other: _____	
Please note that if the request is for an unencrypted electronic delivery method, it may not be secure. The requester acknowledges and accepts risk associated with unencrypted electronic transmission. It is the recipient's responsibility to protect the information once received.	

Section D: Description of the Information to be released/obtained:
The date of service and type(s) of information to be released or obtained are as follows:

The records to be released will cover the time period from _____ to _____

Records from a specific Provider/Clinic: _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Dept. Notes | <input type="checkbox"/> Cardiology Testing Reports | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Inpatient Notes | <input type="checkbox"/> Laboratory/Pathology Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Office or Clinic Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Radiology Images | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Consults | | | |

 Other: _____

