THE University of Vermont HEALTH NETWORK

Champlain Valley Physicians Hospital
75 Beekman Street
Plattsburgh, NY 12901

MRN: _____
Name: _____
DOB: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

BY SIGNING THIS FORM, YOU AUTHORIZE THE SPECIFIED UNIVERSITY OF VERMONT HEALTH NETWORK ENTITY, OR ITS AGENTS TO RELEASE INFORMATION TO THE PARTIES LISTED ON PAGE ONE (1) OF THIS DOCUMENT. PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY THE RELEASE.

I understand and agree that:

- I may be charged a fee for copies in accordance with state and federal law. The fee schedule is available by contacting Health Information Management by **Phone: (518) 562-7930.**
- I can revoke (cancel) this authorization at any time by submitting my request in writing to the Entity to whom I submitted this authorization form. My revocation will not apply to information that has already been released in reliance upon 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 from the organizations, affiliates, or entities within The University of Vermont Health Network.
- **This authorization will expire on _____. If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.**

When a patient is a minor*, or is not competent to give authorization, the signature of parent, guardian or other legal representative is required. Supporting documentation of the legal representative should be provided with this form.**

_____	_____	_____
Signature of Patient/Legal Representative	**Date**	**Time**
_____	_____	
Print Name	**Relationship to Patient (if signed by Legal Representative)**	

Section A

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

Patient Address: _____ **City:** _____

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

Section B: Reason for Release of Information:

☐Medical Care	☐Personal Records	☐Insurance/ Payment	☐Workers' Compensation	☐School:
☐Attorney/Legal Proceedings	☐Provider Transfer	☐Disability	☐Other:	

Section C: Recipient of information:

☐Release a copy of my protected health information (PHI) to me. ☐ Release/disclose my PHI to:

Name:	
Address:	
Phone Number:	Fax Number:
Method of Disclosure: ☐Mail ☐Pick Up ☐Electronic ☐E-mail address: _____	

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

Date of Service or Date Range:_____ **to:**_____

Hospital Record			**Physician Office Records**		
☐**Hospital Abstract** (includes any available documents below **OR** check only those documents needed)			☐**Outpatient Clinic Abstract** (includes any available documents below **OR** check only those documents needed) Clinic/Physician name: _____		
☐Consultation	☐Discharge Summary	☐History and Physical	☐Allergy List	☐Immunizations	☐Medication List
☐ Lab Results	☐ Progress Notes	☐ Rehab Services	☐ Progress Notes	☐Problem List	
Report: ☐Cardiology ☐ED ☐EKG ☐Pathology ☐Operative/Surgical ☐Radiology ☐ Other: _____			☐ Other: _____		

Section E

I understand that the information in my health record may include information relating to sexually transmitted disease, treatment for mental health related issues, treatment of alcohol or drug use disorder and genetic testing or screening results.

By initialing the box below, I authorize the release of this information to the recipient in Section C

Alcohol, Drug, or Substance Use Treatment Records (records from alcohol/drug treatment programs) *	**Initials:**_____
HIV Testing and Results *(requires completion of New York State authorization form for New York hospitals/clinics) **	**Initials:**_____
Mental Health Visits / Psychotherapy Records**	**Initials:**_____
Genetic screening test results	**Initials:**_____

*This form does not require health care providers to release health information. Alcohol/drug treatment-related information and confidential HIV/AIDS-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. (42 CFR Part 2; NYS PBH § 2780)

** Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. (NYS MHY § 33.13)

***NYS Pub Health Law § 17 limits disclosure of prenatal care, abortion, venereal disease testing/treatment (or any other treatment that a minor can consent to without parent consent) to parents without patient consent.

FOR OFFICE USE ONLY	
I have authenticated the identity of the person named in this authorization form via ☐Photo ID ☐Other	
Date Received	**Date Completed**
Employee Signature	