BMH Medical Group
Brattleboro Memorial Hospital
Brattleboro, Vermont

REQUEST FOR USE/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION RELEASE AUTHORIZATION

***Full Name: ____________________________________*Date of Birth: _____________________________**

Address: ____City: ______________ _______ State: _____ Zip: _______

This will authorize BMH Medical Group to use /disclose my individually identifiable health information as described below:

***PREVIOUS HEALTH CARE PROVIDER: ____**
***PHONE #: ( ) __________ - ____________________ *FAX #: ( ) __________ - ____________________**

Health information shall be disclosed to:

Practice Name/Doctor: BMH Medical Group Centralized Scheduling

Phone #: (844) 258-8777 Fax #: (802) 275-3642

Address: 16 Belmont Avenue City: Brattleboro State: Vermont Zip: 05301

Purpose of the use of disclosure (check):
☐Family Education ☒ Continuity of Care (Treatment) ☐Legal ☐OTHER: __________________

***Dates of Care To Include:___________________________________ to: present______________________________**
☒ Doctor/Progress Notes ☒Laboratory Data ☒X-rays, diagnostic testing ☒Discharge Summary
☒Operative Notes ☒ Emergency Room Records ☒Nurse's Notes ☒Problem List ☒OTHER: Medication list and immunization history
***The information authorized for disclosure may include: CHECK all boxes that you want TO BE RELEASED and/or write NO next to the information that you DO NOT want released:**

☐Psychiatric Diagnosis/Treatment Plan ☐ Drug and Alcohol Treatment
☐ HIV/AIDS related illness ☐Hepatitis Status

- I understand that I may inspect or obtain a copy of protected health information described by this authorization.
- I understand that BMH Medical Group shall not condition treatment, payment or enrollment in the health plan of eligibility for benefits on my providing authorization for the requested use of disclosure **AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.**
- I understand that this authorization may be revoked in writing and delivered to BMH Medical Group at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed as a result of this authorization could be redisclosed by the receiver and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that I may be charged for copies.

*__________________ *____
Date Signature of individual/representative
*_____________________________/____________________
Print Name Signed above/Relationship

EXPIRATION DATE: This authorization will expire on (date no later than one year from now):___________
(If no date is stated, this authorization will expire six months from the date it was signed.)
***MANDATORY FIELDS (please complete the asterisked fields)**