BRATTLEBORO MEMORIAL HOSPITAL
17 Belmont Avenue Brattleboro, VT 05301

MRN: _____
Patient Name: _____
Date of Birth: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Authorization to Disclose Protected Health Information Page 1 of 2

1. **BY SIGNING THIS FORM, YOU AUTHORIZE BRATTLEBORO MEMORIAL HOSPITAL AND ITS AGENTS TO RELEASE INFORMATION TO OR RECEIVE INFORMATION FROM THE PARTIES LISTED ON PAGE 2 OF THIS DOCUMENT.**
2. If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative (Health Care Agent or Legal Guardian) must sign and date the form AND attach supporting documentation.

   If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date this form.

   If the patient is deceased, the "next of kin" or executor must sign and date the form AND attach supporting documentation.

3. If the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, your request for information will be submitted for processing.

I understand that:

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health services, and treatment of alcohol or drug abuse.
- I may be charged a fee for copies in accordance with the state and federal law.
- I have a right to revoke this authorization at any time by submitting a written request to the Department or Office where I originally submitted it. 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 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 services at Brattleboro Memorial Hospital.

- **Expiration of Authorization:**

  I understand that this authorization will expire on _____(insert expiration date). If I do not specify an expiration date, this authorization will expire 1 year from the date I signed the authorization.

_____ _____

(**Signature of Patient/Legal Representative)** **(Date)**

_____ _____

(Print Name) **Relationship to Patient (if signed by Legal Representative)**

For office use only: Identification verified by_____ **Date**_____

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AUTHORIZATION FOR RELEASE OF PROTECTED PHI

Patient Address: _____

City:_____ State:_____ Zip Code:_____ Phone #_____

PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would Like information sent to, or information you would like sent from.

☐Send information to: ☐Receive information from:

Name: _____

Address:_____

Telephone Number: _____

☐Current Treatment ☐ Personal Records ☐ Insurance ☐ Worker's Compensation

☐Attorney ☐ Provider Transfer ☐ Disability ☐Other (please specify) _____

Information to be released (please check all that apply, and specify dates)

☐Hospital Abstract (e.g. History & Physical, Operative Report, Test Results, Discharge Summary)
☐Clinic Visit Notes
☐Discharge Summary
☐Lab Reports
☐Operative Reports
☐Pathology Reports
☐Radiology Reports
☐ED Report
☐Immunizations
☐Medication List
☐Other:

Dates of Care to be Released:_____ to: _____
Information Released/Reviewed by: _____ Date:_____