BRATTLEBORO MEMORIAL HOSPITAL
17 Belmont Avenue, Brattleboro, VT 05301
Health Information Management Department
Phone: 802-257-8258
Fax: 802-257-8881

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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. **YOU MUST COMPLETE ALL SECTIONS (*). IF ANY (*) SECTION OF THIS FORM IS INCOMPLETE, THIS FORM MAY BE INVALID.**

3. 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.

4. 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.
- This authorization will automatically expire **12 months from the date signed** unless otherwise specified:

BRATTLEBORO MEMORIAL HOSPITAL
17 Belmont Avenue
Brattleboro, VT 05301

Patient Name _____

Date of Birth _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(*)PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

Patient Address: _____

City:_____ Zip Code: _____Phone #:_____

□ Pick Up □ Send Out

(*)FROM: (e.g. hospital, clinic, or provider name):	**(*)TO: (e.g. to whom you would like information sent):**
Name:_____	Name: _____
Address:_____	Address: _____
_____	_____
Telephone Number:_____	Telephone Number: _____

(*)PURPOSE: (Check the appropriate box)

□ Current Treatment □Provider Transfer □Insurance □Worker's Compensation □Attorney

□ Disability □Personal Records □ Other (please specify):_____

(*) INFORMATION TO BE RELEASED: (Please check all that apply)

□ Hospital Abstract (e.g. History & Physical, Operative Report, Test Results, Discharge Summary)
□ ED Report
□ Discharge Summary
□ Medication List
□ Operative Report
□ Immunizations
□ Clinic Visit Notes
□ Lab Reports
□ Radiology Reports
□ Radiology Images
□ Psychiatric Diagnosis/Treatment
□ HIV/AIDS related illness
□ Drug and Alcohol Treatment
□ Hepatitis Status
□ Other (please specify): _____
_____

VERBAL COMMUNICATION BETWEEN BMH* and: (*BMH will cover all BMH locations)

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone: _____

Dates of Care to be Released: _____ **to**: _____ **(please specify dates)**

Signature of Patient **Date**

Print Name **Description of Authority to Act for Patient (Documents Required)**

For Office use only: Identification verified by (initial):_____(Date):_____ (MRN):_____