COMMUNITY HEALTH

MEDICAL • DENTAL • BEHAVIORAL HEALTH

Financial Services
Attn: Medical Records Department
71 Allen Street, Suite 402
Rutland, VT 05701
Phone 802-671-5800 or Fax 802-772-7973

AUTHORIZATION FOR RELEASE OF COPIES OF A BEHAVIORAL HEALTH MEDICAL RECORD

NAME:_____ **DOB**:_____
(please print)

FORMER NAME:_____ **PHONE**: _____

ADDRESS: _____ **CITY/STATE:**_____

Specify Information To Be Released:

- ❑ Psychiatric Evaluations
- ❑ Psychological Evaluations
- ❑ Treatment Plans
- ❑ Diagnosis
- ❑ Medication History
- ❑ Neurological
- ❑ Psychological Testing Reports
- ❑ School Disciplinary Reports
- ❑ Adaptive Evaluations
- ❑ Educational Reports (i.e. IEP, ER)
- ❑ Behavioral Management Plans (Disciplinary Reports)
- ❑ Transfer/Discharge Summaries
- ❑ Attendance Records
- ❑ Other (Specify):
- ❑ All of the Above/All Behavioral Health Records

Method of Delivery: __ U.S. Mail __ **fax (health providers only**; not to exceed 50 pages) __ CD

❑ Pick-up in Person at Medical Records Department

FORM OF DISCLOSURE: ____ Written ___Verbal

FEES: If paper records are released to the patient fee is $0.50 per page or $5 minimum or a CD is $10 (18 V.S.A. §9419)

( ) Information **REQUESTED FROM:**
Doctor/Facility: _____
Address: _____
Phone/Fax:_____

Specific purpose of topics checked:

- ❑ Coordination of Educational Services
- ❑ Referral to External agency/provider
- ❑ Coordination of Treatment/Services
- ❑ Insurance/Social Security Benefits
- ❑ External Agency/Provider
- ❑ Other (Specify):

( ) Information **RELEASED TO:**
Agency / Entity:_____
Address:_____
Phone/Fax:_____

I request the above information be released. I understand that information released in my medical record may include information on drug and alcohol abuse, psychiatric impairments, AIDS/HIV related illnesses or genetic testing. I understand that I have the right to restrict this information should I choose. I understand that federal regulations (42 CFR part 2) prohibit the re-disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations. I understand that under VT statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures made to organizations outside of the State of VT, all other health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
I understand this authorization is voluntary and can be revoked in writing at any time. A revocation must be submitted in writing to the address above. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released. Authorization to release this information is valid for 12 months from the date of signature on this release. A photocopy or facsimile of this authorization is as valid as the original.
NOTE: Once information has been disclosed, can no longer protect it from Community Health further disclosure.

Signature of Patient: _____ Date: _____
Parent, Guardian or
Legal Representative Signature:_____

****Processing time for a request is usually within 7 to 10 business days after the medical request is received.**
Rev. 2/21 Form #CHC1112BH