COMMUNITY HEALTH

MEDICAL • DENTAL • BEHAVIORAL HEALTH

MEDICAL RECORDS
71 Allen Street, Suite 402, Rutland, VT 05701
Phone 802-671-5800 | Fax 802-772-7973
CHCRR.org

Authorization For Release of Medical Records

NAME (print):_____ DOB: _____

FORMER NAME: _____ PHONE: _____

ADDRESS: _____ CITY/STATE: _____

SPECIFY INFORMATION TO BE RELEASED:

- ☐ Office Visits
- ☐ Lab Results
- ☐ X-Ray/Image Results
- ☐ Immunization Records
- ☐ **Complete Medical Record**
  Date Range: __/__/__ to __/__/__
- ☐ Genetic Testing
- ☐ HIV/AIDS Test Results
- ☐ Other (Please specify for third party records)

_____

Third party records that Community Health has may not be complete. The most complete and accurate records come from the originating provider.

FORM OF DISCLOSURE: ☐ Written ☐ Verbal

METHOD OF DELIVERY: ☐ U.S. Mail ☐ Fax ☐ USB Drive ☐ Patient Pick-Up

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

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
- ☐ Transfer of Care
- ☐ Other_____

☐ Information REQUESTED FROM:

Provider/Facility: _____

Address: _____ Phone/Fax: _____

☐ Information RELEASED TO:

- ☐ Community Health Medical Records, 71 Allen St, Suite 402, Rutland, VT 05701, P: 802-671-5800/F: 802-772-7973
- ☐ Other: _____

  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, Community Health can no longer protect it from further disclosure.

Print Name of Patient	Signature of Patient, or if minor, as applicable, Parent/Guardian/Loco Parentis	Date

Processing time for a request is usually within 7 to 10 business days after the medical request is received.