Diagnostic Imaging Department
P.O. Box 216, Townshend, VT 05353
185 Grafton Road, Townshend, VT
Phone: (802) 365-3625
Fax: (802) 365-3750

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Full Name: ____ Date of Birth_________________

Address: ____

Street / PO Box City State Zip

This will authorize Grace Cottage to release my Medical Records to:

____

(This includes Protected Health Information)

Complete copy of requested records dated____

X-ray Reports________ X-ray CD'S________

⌈ I Understand I may revoke this authorization at any time by providing my written revocation to the disclosing party 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.

⌈ A photo copy of this Authorization is as effective and valid as the original

This authorization will be effective for medical records generated to date of signature.

____ ___________________

Signature of Patient Date

If signed by person other than patient, state relationship/reason

Pt is: Minor_______ Incompetent________ Deceased________Spouse_____

Legal Authority______Parent or legal guardian_______ Next of Kin____ other______ (explain)