CARLOS G. OTIS HEALTH CARE CENTER, INC.
dba Grace Cottage
PO Box 216, Townshend, VT 05353
BEHAVIORAL HEALTH RECORDS AUTHORIZATION
Telephone: (802) 365-7381 · Fax: (802) 365-7548

1. Patient Information:

Patient Name: ____ Date of Birth: ____________________

Street Address: ____ SS#: _____________________________

City, State, Zip: ____

Phone#: (Home) ____ (Work) ____

I authorize the use/disclosure of my behavioral health records and/or information as follows:

2. Party who has my behavioral health records and/or information to use/disclose:

Providers of Grace Cottage Behavioral Health

3. Party who I want to receive my behavioral health records and/or information:

Name: ____

Address: ____

4. Purpose of use/disclosure of my behavioral health records and/or information:

☐ Medical follow-up ☐ Employment reasons ☐ Insurance claim/application

☐ Attorney/legal matter ☐ Personal use ☐ Social security/disability

☐ Transfer of care ☐ Other: ____

5. Dates of records and/or information to be used or disclosed:

Beginning date: _______________________________________ End date: ____

6. Description of my behavioral health records and/or information to be used and disclosed:

☐ Appointment information ☐ Medication information ☐ Billing records ☐ Psychiatry/psychology consultation

☐ Consent forms ☐ Psychiatry/psychology initial evaluation

☐ HIV/AIDS Results/treatment ☐ Psychiatry/psychology therapy notes*

☐ Independent medical/psychological exam ☐ Psychological test data

☐ Other:____ ____

* Psychotherapy notes are notes recorded (in any medium) by a health care provider who is a behavioral health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session.

7. Media Type: If the requested health information is less than 50 pages, paper copies will be supplied. If the requested information is more than 50 pages, a flash drive will be supplied. All flash drives are password protected; please supply a personal password (**required**): ____

8. Expiration

This authorization will expire one (1) year from the date I sign it. If I want it to expire on a different date, then that date is:

____

9. Canceling this authorization

- I may cancel this authorization before it expires by writing a letter stating that I want to cancel it. I must sign the letter and date it. The letter must be sent to Grace Cottage Behavioral Health. The cancellation will take effect when Grace Cottage Behavioral Health receives the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Grace Cottage Behavioral Health received my letter.
- I understand that the requested medical records may contain information pertaining to drug use, alcohol use/treatment, or other sensitive information and agree to the release of this information.
- I understand that authorizing the disclosure of the information identified above is voluntary. This authorization is not intended to alter my ability to receive medical care from any health care provider.

10. My authorization:

____ ____

Signature of Patient Date Signed

____ ____ ______________________

Signature of Legal Representative or Guardian Printed Name of Legal Representative or Guardian Date Signed

The Federal Privacy Rule permits disclosure of protected health information for purposes of treatment, payment, or operation without patient authorization §164.502(a)(1).