PO Box 216, 185 Grafton Rd, Townshend, VT 05353

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) BY GRACE COTTAGE HOSPITAL

(For information to go OUT of Grace Cottage Hospital/Grace Cottage Family Health)

All sections of this form must be filled out completely or it will not be accepted.

- I hereby authorize Grace Cottage Hospital to use/disclose my individually identifiable health information as described below (which may include information concerning treatment for drug /alcohol abuse, mental health, HIV status, or genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form.
- I understand that if the recipient authorized to receive the information is not a covered entity, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations.

Patient Name: _____ DOB:_____

Address:_____ Phone Number: _____

Purpose of the use and/or disclosure: _____

Description of information to be disclosed:_____

☐ **Inpatient** relevant dates :_____

Unless otherwise specified disclosure includes Discharge Summary. Laboratory Reports, Test Results, Consultation Reports and Progress Notes.

Additional/specific information needed: _____

□ **Outpatient** relevant dates or provider name: _____

Unless otherwise specified disclosure includes Ambulatory Care Notes, Laboratory Reports, Test Results and Emergency Department Reports.

The health information shall be disclosed to *(check only one)*: □ Hospital □ Provider Clinic □ Patient

□ Insurance Company □ Attorney □ Friend or Family Member □ Other _____

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

_____

Name Address

_____

City State Zip Code

_____

Phone Number Fax Number

- I understand that I may be charged for copies of my medical records.
- I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify. (Alternative date if desired): _____
- I further understand that I may revoke this authorization at any time by notifying Grace Cottage Hospital in writing, except to the extent it has already been replied upon.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name or Personal Representative Legal Authority of Personal Representative

A parent or guardian is generally required to sign for a patient under the age of 18. Patients aged 12 to 17 should also sign. If an adult is unable to make or communicate medical decisions, the following may sign in the priority given: agent under healthcare power of attorney, guardian, spouse, next-of-kin. Please indicate capacity of representative and have appropriate supporting legal documents available. The Federal Privacy Rule permits disclosure of protected health information for purposes of treatment, payment or operation without patient authorization. §164.502(a)(1)