Grace Cottage Family Health and Hospital
185 Grafton Road/ PO BOX 216
Townshend, Vermont 05353
Main Number: (802)365-7357
FAX Medical Records: (802) 365-7031

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

1. **By signing this form, you authorize Grace Cottage Family Health and Hospital and its agents to release information to or receive information from the parties listed on page 2 of this document.**

2. **You must complete all sections (*). If any section of this form is incomplete, this form may be invalid or you may be contacted for further information.**

3. If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date this form.

4. If the patient is deceased, the "next of kin" or executor must sign and date this form and attach supporting documentation.

5. If the requested health information is less than 50 pages, paper copies will be provided. If the health information is over 50 pages a flash drive will be supplied; please supply a ***password***: _____

I understand that:

- The information to be released may include information related to Hepatitis, Sexually Transmitted Diseases (STDS), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health services, information pertaining to drug use/treatment or alcohol use/treatment, or other sensitive information.
- I may be charged a fee for copies in accordance with the state (**18 V.S.A. § 9419**) and federal statutes.
- I have the right to revoke this authorization at any time by submitting a written request to the Medical Record Department. My revocation will not apply to the information that has already been released.
- Information used or disclosed pursuant to this authorization may be re-disclosed by recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive care at Grace Cottage Family Health and Hospital.
- This authorization will automatically expire **12 months from the date signed** unless otherwise specified.

PATIENT NAME: _____

DATE OF BIRTH: _____

(*) PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent from and whom you would like the information sent to.

Patient Mailing Address:_____

City/Town:_____State:_____Zip Code_____

Telephone Number:_____

☐ PICK UP RECORDS ☐ MAIL RECORDS

(*) FROM (e.g. hospital, clinic or provider name):	**(*) TO (e.g. to whom you would like the information sent):**
NAME_____	**NAME: _____**
ADDRESS: _____	**ADDRESS: _____**
CITY/TOWN: _____	**CITY/TOWN: _____**
STATE: _____ZIP CODE: _____	**STATE: _____ZIP CODE: _____**
TELEPHONE #: _____	**TELEPHONE #: _____**

(*) PURPOSE: (Check the appropriate box): ☐ Current Treatment ☐ Transfer of Care ☐ Insurance ☐ Workers Compensation ☐ Attorney ☐ Disability ☐ Personal Records ☐ Other (please specify):

(*) INFORMATION TO BE RELEASED: (Check all that apply):

☐ Hospital Abstract (History and Physical, test results, Discharge Summary)
☐ ED Report
☐ Discharge Summary ☐ Psychotherapy Notes
☐ Medication List ☐ Behavioral Health Notes
☐ Immunizations ☐ HIV/AIDS/STD Test Results
☐ Clinic Visit Notes ☐ Radiology Reports
☐ Laboratory Results ☐ Other (specify): _____
☐ Drug/Alcohol Treatment ☐ ALL

DATES OF CARE TO BE RELEASED: FROM: _____TO: _____

VERBAL COMMUNICATION BETWEEN GCFHH* and: (*GRACE COTTAGE HOSPITAL AND ALL LOCATIONS)

Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Realtionship:_____Phone :_____

_____

Signature of Patient/Guardian **Date**

_____

Print Name **Description of authority to act for patient (attach document)**