



Grace Cottage Family Health and Hospital
185 Grafton Road/ PO BOX 216
Townshend, Vermont 05353
Main Number: (802)365-4331
FAX Medical Records: (802) 365-3759

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

HIPAA Compliant Release

- 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 the back 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 FAX

(*) FROM (e.g. hospital, clinic or provider name):

NAME _____

ADDRESS: _____

CITY/TOWN: _____

STATE: _____ ZIP CODE: _____

(*) TO (e.g. to whom you would like the information sent):

NAME: GRACE COTTAGE FAMILY HEALTH

ADDRESS: PO BOX 216 185 GRAFTON RD

CITY/TOWN: TOWNSHEND

STATE: VERMONT ZIP CODE: 05353

TELEPHONE #: 802-365-4331

FAX #: 802-365-3759

(*) 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: _____ Relationship: _____ Phone: _____

Signature of Patient/Guardian

Date

Print Name

Description of authority to act for patient (attach document)