SHAFTSBURY MEDICAL ASSOCIATES, INC.
677 VT RTE 7A
PO BOX 379
SHAFTSBURY, VERMONT 05262
PH # (802)442-8531 FAX # (802)442-1503

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME ON MEDICAL RECORDS: ____
DATE OF BIRTH: ____________________________
SOCIAL SECURITY NUMBER: ___________-___________-__________

I HEARBY AUTHORIZE AND REQUEST MY RECORDS BE
SENT TO_______RECIEVED FROM________
(CHECK ONE)

MEDICAL PROFESSIONAL, FACILITY OR PERSONS NAME:

NAME: ____

ADDRESS: ____

CITY: ___________________________ **STATE:** ____________________ **ZIP:** _____________

PHONE #: ________-_______-__________ **FAX #:** ________-________-________

CHECK ONE:

- ☐ **The COMPLETE medical records from this practice. (Including those records received from other medical practices.)**
- ☐ **Medical records concerning my illness/injury and /or treatment during the period From __________to __________, including laboratory reports, x ray, consultation Reports, and other tests reports.**
- ☐ **Other:** ____

The information will be used / disclosed for the following purpose(s):

- ☐ **Requested by the patient and for the patient (not necessary to disclose purpose).**
- ☐ **Transfer of care**
- ☐ **Insurance claim**
- ☐ **Other: (Describe)** ____

- ☐ **I understand that this authorization is voluntary.**
- ☐ **I understand that a fee for cost of processing this request may be charged.**
- ☐ **I understand that I may revoke this authorization at any time by notifying SMAI, in writing, except to the extent that: 1. Action has already been taken in reliance on this authorization; or 2. If this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.**

I understand that my records may include drug/alcohol, HIV and/or mental health records and any other material regarding medical consultations and treatment I have received. By signing below, I authorize release of my records as checked above which may include drug/alcohol, HIV and/or mental health records, unless indicated below. (This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.)

____ **Date:** ________________________
(Patient, Parent or Guardian Signature)

☐ **DO NOT RELEASE DRUG/ALCOHOL, HIV, AND/OR MENTAL HEALTH RECORDS.**

____ **Date:** ________________________
(Patient, Parent or Guardian Signature)

THIS RELEASE EXPIRES ON: ________________________ **STAFF USE:**

_____________ INFORMATION REQUESTED SENT