

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the Shaftsbury Medical Associates Inc. to disclose the following protected health information to:

Facility/Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_

Fax#: \_\_\_\_\_

This authorization permits your facility to disclose the following individually identifiable health information about me:

- All records in your possession, which may include records containing drug and/or alcohol use, HIV and mental health records.
- "Medical Summary" of my healthcare from my electronic/ paper medical record. If this does not provide adequate information for my healthcare provider, I then authorize the release of all records in your possession, which may include records containing drug and/or alcohol use, HIV and mental health records.
- Other specific information related to date, injury, disease, illness, etc: \_\_\_\_\_

This protected health information is being disclosed for the following purposes:

- Transfer of Care       Continuity of Care       Other \_\_\_\_\_

This authorization will be in effect until:

- No expiration       One year from this date at which time this authorization       Other \_\_\_\_\_  
to disclose this protected health information will expire

I understand that I have the right to revoke this authorization, in writing, at any time. My written revocation must be submitted to the Privacy Officer, Michelle Metcalfe, Shaftsbury Medical Assoc. Inc, P.O. Box 379, Shaftsbury, VT, 05262. I understand that a revocation is not effective to the extent that my healthcare provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. My records may be releases by copies sent by mail, fax, or electronic copy by other transferable means.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. 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.)

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name of Personal Representative (please print)

\_\_\_\_\_  
Signature of Patient or Parent/Legal  
Guardian

\_\_\_\_\_  
Date