AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION

Facility/Provider Name: ____

Address: ____

Fax: ______________________________ Phone: _______________________________

I authorize the above facility to disclose the following protected health information to:

Shaftsbury Medical Associates Inc. Attn: Medical Records

| P.O. Box 379 | 677 Vt Rte 7A | Shaftsbury, VT | 05262 | p (802) 442-8531 | f (802) 442-1503

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

- o All records in your possession, which may include records containing drug and/or alcohol use, HIV and mental health records.
- o "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.
- o 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 to disclose this protected health information will expire   Other __________________________

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