LAMOILLE HEALTH PARTNERS

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT PROTECTED HEALTH INFORMATION

PATIENT INFORMATION	**Patient Name:** _____ Date Of Birth: _____ **Address:** _____ Telephone: _____ **City** _____ **State:** _____ **Zip:** _____ ☐ **MAIL RECORDS TO THIS ADDRESS**
CLINIC NAME ***Who*** **has the information you want released? Please list the specific clinic.**	**Name of Clinic*/Person who will release:** _____ **Address:** _____ **Telephone:** _____ **City:** _____ **State** ____ **Zip:** _____
RECEIVING PARTY ***Where*** do you want the information sent? ***Who*** may have the information?	**I authorize release of my protected health information to the following person(s) and/or entities:** **Name of Clinic/Person who will receive:** _____ **Address:** _____ **Telephone:** _____ **City:** _____ **State** _____ **Zip:** _____
INFORMATION TO BE DISCLOSED (***What*** do you want released?) **Check the appropriate box**	**I authorize release of the following parts of my medical record:** ☐ **Complete Medical Record. Date(s) of Information to be Disclosed: From** __/__/__ **TO** __/__/__ (If you do not specify a date range, information from the past two years only will be released). If you do not wish to release a complete copy of your record, specify the information to be released: ___ Office Visits ___ Genetic Testing ___ Laboratory/Pathology Results ___ HIV/AIDs Test Results ___ X-Ray/Image Results ___ Other _____ ___ Immunization Records Third party records that Lamoille Health Partners has may not be complete. The most complete and accurate records come from the originating provider.
Release Instructions ***How*** do you want the information?	**Format requested: (check one)** **Release Method** ☐ **Paper** ☐ **Disk/CD** ☐ **Mail my Records** ☐ **Will be picking up at the clinic** You may be charged a fee for paper copies in accordance with state and federal law and Lamoille Health Partners policy. See Page 2 additional info.
Purpose of Release (***Why*** is it needed?)	☐ **Continuing care** ☐ **Transfer of care** ☐ **Social security** ☐ **Insurance application *** ☐ **Personal use or review *** ☐ **Disability** ☐ **Insurance payment/claim determination** ☐ **Litigation/legal**

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled (or "revoked') in writing at any time, except to the extent Lamoille Health Partners has acted in reliance on the authorization. A cancellation will not change releases that happen before the cancellation. The Lamoille Health Partners Notice of Privacy Practice describes how to cancel this authorization.
- Lamoille Health Partners will not restrict my treatment if I choose not to sign this authorization. A photocopy/fax of this authorization will be treated in the same way as an original. Lamoille Health Partners records may include records that it received from other organizations. If these records have been used by Lamoille Health Partners and filed in the record Lamoille Health Partners maintains about you, these records may be released with your Lamoille Health Partners Health records.
- Lamoille Health Partners cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Lamoille Health Partners from any, and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.
- ** Notice Prohibition Redisclosure of Substance Use Disorder Treatment Record Release: This information has been disclosed to you from the records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

_____ __/__/__ _____

Patient/Legal Representative Signature **Date** **Print Name:**

Legal Guardian/Executor/Power of Attorney Documentation on file or attach and scan

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Directions for Completion of Form

YOU MUST COMPLETE ALL SECTIONS. IF ANY SECTION OF THIS FORM IS INCOMPLETE, THIS FORM MAY BE INVALID

Patient Information: Complete the entire section which identifies clearly and legibly all the demographic information specific to the patient (individual who information is being requested for).

Clinic/Health care Provider: Identify which Lamoille Health Partners clinic you are seeking information from (or to be sent to). **Please be specific** in your request. For example, "Lamoille Health Family Medicine, Morrisville."

Receiving Party: Identify the full name/business, address, phone and contact information with the name of the individual who is *to receive* the information. It is Lamoille Health Partners policy to fax or electronically send patient information for direct patient care to the provider. Please note: It is Lamoille Health Partners policy **NOT** to fax or email patient information except for direct patient care requirements.

Information to Be Disclosed: This section gives us the instructions for what information you want released. If you leave the dates of information to be disclosed blank, we will send you medical records from the prior two years. This is typically what doctors' offices, hospitals or other health care providers need for information related to your care.

Payment of Fees for Copies. You may be charged a fee for copies in accordance with state and federal law and Lamoille Health Partners policy. The fee schedule is available by contacting Health Information Management at 802-888-5639, Monday-Friday 8:30 am to 4:30 pm.

Release Instructions: This tells us what format and how you would like your medical record delivered to you. We can print the documents or create a CD and mail them or they can be picked up at the clinic. Authorizations cannot be predated for action in the future. Lamoille Health Partners must be able to act upon a release of information upon receipt of this Authorization.

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Who must sign: If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative (Health Care Agent or Legal Guardian) must sign and date the form AND attach supporting documentation. If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date this form. If the patient is deceased, the "next of kin" or executor must sign and date the form AND attach supporting documentation.

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date or event. You may indicate the consent is valid "5 years", "10 years", but there needs to be an ending date. The authorization is revoked at your written direction to our organization.

For a list of Lamoille Health Partners locations and addresses, please visit www.lamoillehealthpartners.org