LAMOILLE HEALTH
BEHAVIORAL HEALTH & WELLNESS

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT PROTECTED HEALTH INFORMATION
Behavioral Health & Wellness

PATIENT INFORMATION	**Patient Name: _____ Date of Birth: _____** **Address: _____Telephone: _____** **City: _____ State: _____ Zip: _____**
CLINIC NAME ***Who* has the information you want released?** **Please list the specific clinic.**	**Records From:** **Name of Clinic*/Person who will release: _____** **Address: _____ Telephone: _____** **City: _____State: _____ Zip: _____ Fax: _____**
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: _____ Fax: _____**
INFORMATION TO BE DISCLOSED (***What*** do you want released?)	☐ **I authorize Verbal sharing of information with: _____** **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: **** VT statute 144.292 and Federal Rule 45 C.F.R. §164.524 - You must Check below for the following information to be release:** ____ Alcohol/Drug Abuse Treatment _____ Mental Health Records _____HIV test results Or Records related: (specific Condition, treatment, etc.) _____
Release Instructions	**(check one)** **Format requested: _____Paper _____ Disk/CD**
Purpose of Release (***Why*** is it needed?)	**(check one)** **Transfer of care_____ Continuation of care _____ 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 Health 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 Behavioral Health & Wellness."

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