Protected Health Information Release Authorization

The Health Center
PO Box 320, Plainfield, VT 05667
Dental – 802-454-1047/tel. 802-322-0714/fax

Full Name: _____ Date of Birth: _____ SS #: _____
Address: _____
_____ Tel No.: _____

This will authorize: _____
_____
_____

To exchange/disclose my protected health information with/to:

The Health Center
Attn: Dental
PO Box 320
Plainfield, VT 05667-0320
Email: Dental.office@the-health-center.org

As described below for the following purposes:
____Complete copy of medical records ____Complete copy of dental records & ***x-rays**
____Complete copy of mental health records ____Other (describe): _____

Dates of care included: _____to_____

The information authorized for disclosure may relate to: (check all that apply):
_____HIV related illness _____AIDS _____Drug or alcohol treatment
(further redisclosure prohibited or governed by 42 CFR part 2)

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that this authorization may be revoked in writing and delivered to The Health Center at the above address at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on my authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that The Health Center shall not condition treatment on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.

Date: _____ _____
Signature of patient or representative

_____
Relationship to patient

This authorization will automatically expire three years from the date the patient transfers his/her care to another provider.

***Please email digital x-rays. No photocopies please.**