Protected Health Information Release Authorization

The Health Center
PO Box 320
Plainfield, VT 05667
802-454-8336 fax 833-464-5249

This will allow your previous primary care and specialty providers to send us a copy of your records.

Full Name:_____

Date of Birth:_____

Address: _____

_____

This will authorize: _____
(previous providers) _____

_____

_____

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

The Health Center
PO Box 320
Plainfield, VT 05667

as described below for the following purpose: continuity of care

____Complete copy of medical records ____Complete copy of dental records & xrays

____Complete copy of mental health records ____Other (describe): _____

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 redisclosure 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.