Gifford

Protected Health Information Release Authorization

Instructions for Release of Information

Please make sure all steps are completed before returning.

Section 1 – Information about you:
This is information about you. We need this section filled out completely, including name, date of birth, address, phone number, etc.

Section A – Who has your medical record now:
This is where your information is currently located. Please fill out the name and address of the doctor and/or hospital that has your medical record.

Section B – To whom do you wish to release your records:
Where do you want your medical record to go? Please fill out the name and address of the doctor and/or hospital where you want your information sent.

Do you want a family member to have access to your health information? Please complete this box if you would like your care to be discussed with another person such as your child, parent, spouse, significant other, or another individual who may be a support person.

For the purpose of: Please indicate the reason you are asking for release of information.

Authorize for release: Either check the box for verbal communication only or fill out the date range and the type of records you wish to be released.

Date and Sign: Date and sign the release.

Expiration date: Please indicate when you would like your release to expire. If you do not fill this section out, your release will expire 1 year from the date it was filled out.

Fee: There may be a fee associated with the release of your records. This usually applies for copies of your records for personal use or records sent to attorneys. There is a flat fee of $5.00 for the first one (1) through ten (10) pages. After that, it is $0.50 per page. There is no fee when records are released directly to another physician or hospital.

If you are requesting records to be released from Gifford to another facility, make sure the information is legible and signed release is returned to:

Gifford Medical Center
Attn: Barbara Conant, Health Information Management
PO Box 2000
44 South Main Street
Randolph, VT 05060

If you are requesting information from another facility be sent to Gifford, make sure the information is legible and signed release is returned to the facility where you are requesting records from.

Any questions or concerns, please contact Barbara Conant at:

Telephone: (802) 728-2223
E-mail: bconant@giffordmed.org
Fax: (802) 728-2394

Gifford

Gifford Medical Records Department
Phone: (802) 728-2223 | Fax: (802) 728-2394

Health Information Release

Patient Name _____ Maiden Name _____
SS# _____ Date of Birth _____
Home Phone _____ Cell/Work Phone _____
Address _____ Email _____
City/State/Zip _____ Release paper records now ☐ Yes ☐ No

A) FROM: I hereby authorize/request information from:

Name _____
Address _____
City _____
State _____ Zip _____
Phone _____
Fax _____

B) TO: To be released to: ☐ Bi-directional communication

Name _____
Address _____
City _____
State _____ Zip _____
Phone _____
Fax _____

For the purpose of:

☐ Litigation
☐ Payment
☐ Self/Personal Care
☐ Transfer Care
☐ Other
☐ Disability
☐ Work Comp
☐ Care Management
☐ Continuity of Care

Please indicate the type of information you authorize for release:

Check this box if this form authorizes **verbal communication** only ☐
Date Range: _____ to _____

☐ Physician Office Notes
☐ Medical Summary
☐ Operative/Procedure Reports
☐ Billing/Payment Records
☐ Behavioral Health Records
☐ Other _____
☐ Cardiology/EKG Reports
☐ Lab/Path Reports
☐ Radiology/XRay/MRI Reports
☐ Dental Records
☐ Substance Use Records

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral and mental health services, and treatment for alcohol and drug abuse through Gifford's general provision of health care. Gifford employs certain staff members who provide substance use disorder diagnosis, treatment, or referral for treatment through Gifford's Addiction Treatment Program. I understand records created as part of this program are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. In addition, I understand that this consent form does not apply to my records that do not identify me, directly or indirectly, as an individual participating in a program for substance use disorders. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I can do so in writing or verbally. However, it is highly recommended to send a written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Date (Signature of ☐ Patient ☐ Parent ☐ Guardian ☐ Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____
Expiration date of authorization