Gifford

Gifford Medical Center (GMC) • Gifford Health Care (GHC) • Gifford Retirement Community (GRC)
44 South Main Street, P.O. 2000 • Randolph, Vermont 05060
802-728-2223 • *fax* 802-728-2394 • inforelease@*giffordhealthcare.org*

Authorization Form for Release/Request of Medical Records

(This form must be completed in full before signing)

Patient Full Name: _____ Date of Birth: _____ Phone: _____

Address: _____ Email Address: _____
Street City State Zip

I hereby authorize: ☐ GMC ☐ GHC ☐ GRC to: ☐ Send/Release Information to: ☐ Receive Information From:

Name: _____ Address: _____

Phone Number: _____ Fax Number: _____

Delivery Method (Please check one): ☐ Email ☐ Mail ☐ Fax ☐ Pick-up

Check the type of Information to be Released/Requested (check all applicable):

☐ Emergency Record ☐ Clinic/Office Visit ☐ History & Physical ☐ Lab/Path Results ☐ Immunization Records
☐ Radiology Report ☐ Radiology Images ☐ Medication Records ☐ Discharge Summary ☐ Cardiology Report
☐ Ambulance Reports ☐ Operative Report ☐ PT/OT Rehab Notes ☐ Itemized Bill
☐ Other _____

SENSITIVE INFORMATION:(*Please Initial*) Behavioral Health _____ HIV/AIDS _____ Drug or Alcohol** _____

Dates of Treatment or Care to be Released: From _____ To _____

The purpose for the request/release: _____

I hereby authorize: ☐ GMC ☐ GHC ☐ GRC to release my information to my personal representative:

Name: _____ Relationship: _____

I understand this request is for information available at Gifford Medical Center, Gifford Health Care and Gifford Retirement Community at the time of the request and will **expire one year** from the date signed below.

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

**I understand that my records are protected under federal privacy laws and regulations and the General Laws of Vermont and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug misuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse. May need to sign separate authorization form.

_____ _____
Signature of Patient, Legal Guardian or Representative **Date**