



Gifford Health Care
 Gifford Medical Center Gifford
 Retirement Community
 44 South Main Street, P.O. 2000
 Randolph, Vermont 05060
 Phone: 802-728-2223
 Fax: 802-728-2394

Patient Name: _____

Acct Number: _____

Med Rec Number: _____

Age: _____ Gender: _____

DOB: _____

Svc Date: _____

Authorization for Release/Request of Protected Health Information

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

Address: _____ Email Address: _____

Street, City, State Zip

I hereby authorize Gifford Health Care to: Release Information Receive Information
 Patient/Proxy Portal Access Permission to Speak

Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Fax Number: _____ Email Address: _____

Delivery Method (Please check one): Email Mail Fax Patient Portal Pick-up Verbal

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

<input type="checkbox"/> Emergency Record	<input type="checkbox"/> Clinic Office Visit	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Lab/Path Results	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Cardiology Report
<input type="checkbox"/> Ambulance Reports	<input type="checkbox"/> Operative Report	<input type="checkbox"/> PT/OT Rehab Notes	<input type="checkbox"/> Itemized Bill	<input type="checkbox"/> Menig
<input type="checkbox"/> 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 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, or otherwise indicated:

Date of Expiration: _____

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 to 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, you must initial above before disclosure of such information. I understand Patient portal access does not allow limitation of protected health information. **

 Signature of Patient, Legal Guardian or Representative

 Date