AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient's Name ______________________________ Date of Birth ______________

Pt Address ____

Pt Phone # ______________________

I request and authorize

Vermont Gastroenterology

875 Roosevelt Highway, Suite 132, Colchester, VT 05446

Phone: 802-864-7483 Fax: 802-660-4337

to release healthcare information of the patient named above to

Name (Doctor, Office) ______________________________________

Address ____

Phone ______________________ Fax ______________________

This request and authorization applies to

- ☐ Healthcare information relating to the following treatment, condition or dates:

- ☐ Other:

Indicate Purpose: At individual's request/Other ______________________________

Authorization re: sensitive Information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, Vermont Gastroenterology will release such information about me if it exists.

- ☐ HIV/AIDS
- ☐ Genetic Information
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ Sexually Transmitted Diseases
- ☐ Treatment for alcohol and/or drug abuse

I understand that

- this authorization will expire in one (1) year from the date signed below
- I may revoke this authorization by notifying the sending office, but that any previously disclosed information would not be subject to such revocation
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or my eligibility for benefits, unless otherwise described in the space provided here:
- there is a potential for the information disclosed to be subject to re-disclosure by the recipient if the recipient is not required by law to protect its privacy.

Patient's Signature ______________________________ **Date Signed** ______________

Personal Representative Signature ______________________ **Authority** ______________

Date Signed ______________