Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____ MR #: _____
Please Print

Address: _____
Please Print

I hereby authorize SVHC the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. This authorization is valid for 1 year unless otherwise specified.

Name and Address of Persons/Organizations authorized to receive information:

_____

_____

Specific description of information that may be used/disclosed and dates of service:

- ☐ X-ray Films and Report
- ☐ Office Notes
- ☐ ER Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Outpatient Department
- ☐ Other _____
  Describe

This authorization permits SVHC to disclose my protected health information from my health record with no limitations placed on history of illness, diagnostic or therapeutic information including any treatment for alcohol and drug abuse, psychiatric impairment, HIV/AIDS related illnesses or genetic testing.

The information will be used / disclosed for the following purpose(s):

- ☐ Requested by the patient and for the patient (not necessary to disclose purpose).
- ☐ Insurance Claim
- ☐ Other: (Describe) _____

_____

- ☐ I understand that this authorization is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to ensure healthcare treatment.
- ☐ I understand that I may inspect or copy the information used or disclosed.
- ☐ I understand that I may revoke this authorization at any time by notifying SVHC, in writing, except to the extent that:
  1. Action has been taken in reliance on this authorization; or
  2. If this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

_____ _____
Signature of Patient or Patient Representative Date

_____
Relationship to patient, or representative's authority to act for the patient (if applicable)

Request Received: _____ Date Processed: _____ ☐ Copy of Authorization given to the individual
Date Date

Initial of person finalizing request: _____