Dartmouth Health
Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Authorization for Release of Information and/or Radiology Films

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

Address:_____ Phone#: _____

I hereby authorize SVMC 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 one (1) year unless otherwise specified.

I understand that SVMC may charge me a reasonable cost−based fee for postage and/or printing of documents and I agree to pay this amount.

Recipient/Organization Name: _____

Address:_____

Phone#: _____ Fax#: _____

Specify description of information that may be used/disclosed and dates of service (if applicable)

- ☐ Imaging Film(s)
- ☐ Imaging Reports
- ☐ Office Notes
- ☐ ER Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Report
- ☐ Outpatient Services (Lab, EKG, EEG, Echo)
- ☐ Other_____

Date(s) of Service: ☐ All **OR** ☐ Date Range: _____ to _____

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

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

This authorization permits SVMC 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.

I understand this authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any reports or images already released under this authorization.

I understand 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.

_____	_____	_____	_____
Patient or Patient Representative	Relationship to Patient	Date	Time

For SVMC Use Only

Date Received: _____ Date Completed: _____ User Mnemonic: _____

Patient Records: ☐ Mailed ☐ Faxed ☐ Provided to Patient/Representative

Images: ☐ CD ☐ Pushed to PACS/PowerShare