



Evergreen Family Health
 28 Park Ave, Williston, VT 05495
 Phone (802)878-1008 Fax (802)872-2679 www.evergreenhealth.org

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____ Date of birth: _____
 (Name of patient whose information is being requested)

Authorize EVERGREEN FAMILY HEALTH Phone:#: 802-878-1008
 (Name and address of person/agency sending information) (Phone # of sending facility)

to disclose to: _____ Phone #: _____
 (Name and address of person/agency receiving the information) (Phone # of receiving facility)

The purpose of this disclosure is:

- Changing doctors/office Share records with seasonal physician Seeking consult/2nd opinion For my personal records (fee may apply)

Please check all information you would like to have shared*:

- Entire Record** Immunizations Other (please specify): _____

*The information to be released may include information related to Hepatitis, sexually transmitted diseases, AIDS, HIV, genetic testing, behavioral or mental health services, and treatment of alcohol or drug abuse.

Please initial if you wish not to release:

_____ Protected psychiatric, psychotherapy, alcohol and/or substance abuse treatment notes.

- I waive my right to review my medical records before they are released.

Name: _____ Date: _____

****Signature:** _____
 (Patient/Legal Representative) (Relationship to Patient if signed by Legal Representative)

***Please note: Unless otherwise specified, this release expires one year from signature date above. You have the right to revoke permissions granted in this document by notifying us in writing of your desire to do so. Your treatment, payment, enrollment or eligibility for benefits will not be conditioned upon whether or not you sign this authorization. Your signature on this authorization indicates that you understand the information disclosed under this authorization form may be re-disclosed by the receiving person(s) or facility and would then no longer be protected by federal privacy regulations.*