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.*