EVERGREEN
FAMILY HEALTH GROUP

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)

Please check all information you would like to have shared:

Medical Summary
Past year of office visit notes
Immunizations
Health Screenings (colonoscopy, mammogram, etc.)
Imaging Reports
Consultation Notes
All Medical Records
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: _____

Date of Birth: _____ Phone number: _____

****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 you sign this authorization. ****

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