EVERGREEN
FAMILY HEALTH GROUP

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

The purpose of this disclosure is to transfer records and care from Evergreen Family Health.

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

Authorize _____ **Phone #: _____**

to disclose to: **EVERGREEN FAMILY HEALTH** **Phone**: #: 802-878-1008 **Fax:** 802-652-5355

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
___3-5 Years
___All Medical Records

Other (please specify): _____

Reason for Release: _____

Please initial if you wish to release:

_____Mental Health Records

_____Confidential HIV/AIDS Information

_____Substance, Drug, Alcohol Use Disorder Records

_____Genetic Testing Results

_____Sexually Transmitted Disease (STI) Records

Please Initial If:

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

Name: _____ Date: _____

Date of Birth: _____ Phone number: _____

****Signature:** _____

(Patient/Parent/Legal Representative) (Relationship to Patient)

***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. ***

Evergreen Family Health
426 Industrial Ave STE 130
Williston, VT 05495

Evergreen Sports Medicine
426 Industrial Ave STE 130
Williston, VT 05495

Alder Brook Family Health
8 Essex Way STE 201
Essex, VT 05452