BRATTLEBORO MEMORIAL HOSPITAL
Brattleboro, Vermont
REQUEST FOR USE AND/OR DISCLOSURE OF
Protected Health Information Release Authorization

MR#

Full Name:_____ Date of Birth:_____

Address:_____

City_____State_____Zip_____

This will Authorize Brattleboro Memorial Hospital to use/ disclose my individually identifiable health information as described below.

Health information shall be disclosed to:

Name:_____

Address:_____

City_____State_____Zip_____

Purpose of the use of disclosure:
☐**Family Education** ☐**Continuity of Care** ☐**Legal** ☐**Other**_____

☐Discharge Summary ☐Laboratory Data ☐Progress Notes ☐History & Physical Exam ☐ Emergency Room Records ☐Operative Note ☐Nurse's Notes ☐X-ray, Scans, Etc. ☐Other
Dates of care included:_____ to _____

The information authorized for disclosure may include: (CHECK all boxes beside the information that you want TO BE RELEASED and/or write NO beside the information that you DO NOT want to be released.)
☐Psychiatric Diagnosis/Treatment Plan (excluding psychotherapy notes) ☐ Drug or alcohol treatment ☐ HIV/AIDS related illness ☐Hepatitis Status

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that Brattleboro Memorial Hospital shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use of disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that this authorization may be revoked in writing and delivered to the HIM Department of Brattleboro Memorial Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed as a result of this authorization could be redisclosed by the receiver and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand I may be charged for copies.

_____ _____
Date Signature of individual or representative/Print name signed and Authority or relationship to patient

_____ _____
Witness Print Name Signed

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EXPIRATION DATE: This authorization will expire on (date no later than one year from now) _____.
(If no date is stated, this authorization expires six months from the date it was signed.)

At your request we will provide you a copy of this form.