Vermont Naturopathic Clinic

Providing integrative medicine for Vermonters…naturally!

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient name:_____ DOB:_____

I authorize: *(Name of location or doctor that will be SENDING records)*	To disclose health records to *(Name of location or doctor that will be RECEIVING records)*
Name:	
Address:	
City, State, Zip:	

Records released to include the following:

☐ all records ☐ Laboratory/pathology records ☐ X-ray/radiology records specific records:

☐ Other:_____

For the dates of _____ to _____

This authorization expires: may be a specific date or a condition, if left blank, expires 12 months from date of signature: _____

I understand that:

- My health information may include general information related to mental health services, treatment for drug/alcohol abuse, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), communicable diseases, abortion or other information I may consider sensitive.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the sole purpose of treatment is to provide information to a third part. I may inspect or copy any information used/disclosed under this authorization and understand there may be a fee for copying my health information.
- This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of Vermont Naturopathic Clinic, PLC. I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.
- If the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations in which case I do not hold Vermont Naturopathic Clinic, PLC legally liable for such redisclosure.

The information will be used/disclosed for the following purpose(s):

☐ At my request (only the patient can check this box)
☐ For payment/health insurance
☐ Social Security/Disability
☐ Worker's Compensation
☐ For my health care provider
☐ For employment purposes
☐ Certification Attorney Inquiry/Legal Matter
☐ Other:_____

_____ _____

Signature of Patient (or his/her authorized representative, or parent or guardian) Date

Please specify relationship to patient/client if a minor.: _____

Date sent:_____ Initials:_____