BRATTLEBORO MEMORIAL HOSPITAL
17 Belmont Avenue, Brattleboro, VT 05301
Health Information Management Department
Phone: 802-257-8258
Fax: 802-257-8881

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. **BY SIGNING THIS FORM, YOU AUTHORIZE BRATTLEBORO MEMORIAL HOSPITAL AND ITS AGENTS TO RELEASE INFORMATION TO OR RECEIVE INFORMATION FROM THE PARTIES LISTED ON PAGE 2 OF THIS DOCUMENT.**

2. **YOU MUST COMPLETE ALL SECTIONS (*). IF ANY (*) SECTION OF THIS FORM IS INCOMPLETE, THIS FORM MAY BE INVALID.**

3. If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative (Health Care Agent or Legal Guardian) must sign and date the form AND attach supporting documentation.

   If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date this form.

   If the patient is deceased, the "next of kin" or executor must sign and date the form AND attach supporting documentation.

4. If the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, your request for information will be submitted for processing.

I understand that:

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health services, and treatment of alcohol or drug abuse.
- Reproductive Health Care refers to health care that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes, that may include Gender Affirming Care.
- I may be charged a fee for copies in accordance with the state and federal law.
- I have a right to revoke this authorization at any time by submitting a written request to the Department or Office where I originally submitted it. My revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health services at Brattleboro Memorial Hospital.
- This authorization will automatically expire **12 months from the date signed** unless otherwise specified:

BRATTLEBORO MEMORIAL HOSPITAL
Name 17 Belmont Avenue
Brattleboro, VT 05301

Patient:

Date of Birth:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(*)PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

Patient Address:

City: Zip Code: Phone #:

☐ Pick Up ☐ Send Out

(*)FROM:(e.g. hospital, clinic, or provider name):	**(*)TO:(e.g. to whom you would like information sent):**
Name:	Name:
Address:	Address:
Telephone Number:	Telephone Number:

(*)PURPOSE: (Check the appropriate box)

☐ Current Treatment ☐Provider Transfer ☐Insurance ☐Worker's Compensation ☐Attorney

☐ Disability ☐Personal Records ☐ Other (please specify):

(*) INFORMATION TO BE RELEASED: (Please check all that apply)

☐ Hospital Abstract (e.g. History & Physical, Operative Report, Test Results, Discharge Summary)	☐ Immunizations	☐ Psychiatric Diagnosis/Treatment
☐ ED Report	☐ Clinic Visit Notes	☐ HIV/AIDS related
☐ Discharge Summary	☐ Lab Reports	☐ Drug and Alcohol Treatment
☐ Medication List	☐ Radiology Reports	☐ Hepatitis Status
☐ Operative Report	☐ Radiology **Images**	☐ Reproductive Health/Gender Affirming Care

☐ Other (please specify): _____.

VERBAL COMMUNICATION BETWEEN BMH* and: (*BMH will cover all BMH locations)

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: _____ Relationship: _____ Phone: _____

Dates of Care to be Released: _____**to**: _____ **(please specify dates)**

Signature of Patient **Date** .

Print Name **Description of Authority to Act for Patient (Documents Required)**

For Office use only: Identification verified by (initial): _____ (Date): _____ (MRN):