Porter Medical Center, Inc.
PATIENT AUTHORIZATION - MEDICAL INFORMATION

Your medical records cannot be released or obtained until this form is completed and signed by the patient or legal representative. Requests for copies of medical records are subject to reproduction fees in accordance with applicable law.

Patient Name: ____ Date of Birth: _____________________

Address: _______________________________ City: _________________________ State: _____ Zip: ________

Phone: ____ E-mail: ____________________________________

I hereby authorize ______________________________________ to take the following action:
Porter Medical Center, Inc. (Facility)

□ Provide a copy of my protected health information (PHI) to me.
□ Release my PHI to:
□ Discuss my PHI with:
□ Obtain copies of my PHI from:

Person or Entity: _________________________________ Telephone: _______________________

Address: ___________________________ City: _____________ State: _____ Zip: ______________

Fax: (Health care provider only) ____________________________

Purpose for releasing information: ☐Continuation of care ☐ Personal ☐ Transfer of Care ☐ Insurance ☐ Legal

I authorize the following PHI to be released: ☐ Office Notes (PCP) ☐ Continuation of Care documents ☐ Lab ☐ Radiology
☐Immunization records ☐ Medications ☐ ER record ☐ Complete Medical Record (all pages)
☐ Abstract (includes History and Physical, Operative report(s), Consultation(s), test result(s) and Discharge Summary)
☐Other: ____ Dates of Service: ________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, treatment for mental health related issues, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained *(include dates where appropriate)*

Alcohol, Drug, or Substance Abuse Records	□ Yes	□ No	Dates: ____________________________
HIV Testing and Results	□ Yes	□ No	Dates: ____________________________
Mental Health Records	□ Yes	□ No	Dates: ____________________________
Psychotherapy Records	□ Yes	□ No	Dates: ____________________________
Genetic	□ Yes	□ No	Dates: ____________________________

By signing this authorization form, I understand that: Federal confidentiality rules (42CFR Part 2) prohibit the recipient of my health information from re-disclosing any of my federally protected drug and alcohol treatment information without my express written consent or as allowed by the regulations. I also understand that under Vermont statute, my health information can only be disclosed with my authorization/consent or as mandated by and express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all health information (other than my federally protected drug and alcohol treatment information) used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 and Vermont Law.

- I have the right not to sign this authorization
- My medical treatment is not dependent upon signing this authorization.
- I have the right to inspect or copy the information disclosed and I have the right to obtain a copy of this authorization.
- I have the right to revoke this authorization at anytime. Revocation must be in writing and sent to the Health Information Management Department , 115 Porter Drive, Middlebury, VT 05753 (revocation will not apply to information that has already been released in response to this authorization.)
- Unless otherwise revoked, this authorization will expire on the following date: ________________________
- If I fail to specify an expiration date, this authorization will expire in six (6) months.

_____________________________________ __________ ____________________

Patient or Legal Representative Signature *Date* *Relationship*

(For office use only) – Medical Record Number ____________________________ Date completed____________________Initials__________

Effective Date of Form: June 4, 2015 Approved by HIM and Compliance