CONSENT TO DISCLOSE HEALTH INFORMATION

I, ____ (_________________)
Patient Name (print) *Date of Birth*

Authorize ____
Name, fax # and address of person/agency SENDING information

To disclose to: ____
Name of person/agency RECEIVING the disclosure. If not Richmond Family Medicine, specify fax # and address

The **PURPOSE** of this disclosure is:

❑ I am transferring my medical care ❑ Coordination of care with another medical provider
❑ Legal ❑ Life or other insurance ❑ Other:____

I would like to disclose the following information:			
❑	My medical record, including a medical summary and detail for the last 2 years		
❑	My medical record, including a medical summary and detail for from (____/____/____ through ____/____/____)		
❑	My medical record, including all available records regardless of date		
OR (select all that apply)			
❑	Medications	❑	Progress notes
❑	Test Results	❑	Diagnosis/Problem information
❑	Immunization history	❑	Appointment history
❑	HIV/AIDS Diagnosis & Treatment information	❑	Psychiatric/Mental Health records
❑	Billing/insurance related records	❑	Other

★Please provide *any exceptions, restrictions or limitations* for this disclosure: (time limits, specific tests, etc.): ★
____
____

This consent to disclose information will expire on: _______________. I understand that if I do not note a date or event, then this consent will expire one year from the last date of service to me at the facility. I also understand I have the option to revoke this consent at any point. If revoking consent, please provide today's date here:__________________.

I understand that information released may include medical, mental health, and/or drug and alcohol information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it. A photocopy or facsimile of this consent is as valid as the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for any other purposes. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damage resulting from the lawful release of my protected health information. I also understand that any fees as a result of this request are my responsibility.

____ ________________________
Patient Signature Date

____ ________________ ________________________
Parent, Guardian, Legal Representative Signature (Relationship) Date

Was any assistance provided in completing this form? ❑ Y ❑ N Name of assistant:____

Summary of assistance provided:____

ATTENTION FACILITIES SENDING RECORDS TO RICHMOND FAMILY MEDICINE: Electronic records are preferred. Inbound faxes are received in a secure system, directly routed to our EHR. We also are enrolled in the SureScripts Net2Net network.

Richmond Family Medicine ● 30 West Main Street ● Richmond, VT 05477 ● Phone: 802.434.4123 ● Fax 802.434.3130