Consent to Release Information

I, _____ Date of Birth _____

Phone: _____

Authorize:

_____

_____

_____

To disclose to:

Winooski Integrative Medicine, PC
321 Main Street, Suite B
Winooski, VT 05404

The purpose of this disclosure is for:

_____ Transfer of care
_____ Consultation
_____ Other (Please explain) _____

Please check all information you would like to have shared:

__ Entire Medical Record
__ Problem List
__ Medication List
__ Surgical History
__ Allergy List
__ Other (Please specify) _____

Past 1 year of office notes ___
Treatment plans _____
Test Results _____
Immunizations _____
Family History _____

Time period or other specifics related to the information to be disclosed:
___ From _____ to _____ or-
___ All past, present, and future periods
___ The date of the document signature until the following event: _____

You are authorizing Winooski Integrative Medicine to disclose your records in the following formats: Written, verbal, electronic, unless otherwise specified here: _____

I understand that information released may include information related to (check all that apply):

__ Medical __ HIV and AIDS __ Genetic testing __ Hepatitis
__ Psychiatric/Mental Health __ Hepatitis __ Sexually transmitted diseases
__ Treatment of alcohol or drug abuse

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Records 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Part 160 and 164, unless otherwise provided for by the regulations.

I also understand that I may revoke this consent at any time by notifying us in writing of my desire to do so 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 there are limited circumstances where I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations.

Date or even upon which this consent will expire _____

I understand if I do not state a date or even, then this consent will expire one year from the last date of service to me at Winooski Integrative Medicine, PC.

Your signature on this authorization indicates that you understand the information disclosed under this authorization form and may be re-disclosed by the receiving person(s) or facility and would then no longer be protected by federal privacy regulations.

__ I waive my right to review my medical records before they are released.

Signature _____ Date _____

Legal Representative Printed Name: _____

Legal Representative Signature: _____ Date _____