Mountain Community Health

61 Pine Street,
Bristol, VT 05443

Release of Information Authorization

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

Home Phone: ( )_____ **Cell Phone**: ( )_____ **Work Phone**: : ( )_____

- I understand that Mountain Community Health (MCH) may share my Protected Health Information (PHI) with other healthcare providers and entities for purposes of treatment, coordination of my care, referral to other treatment facilities, practice operations, processing, and payment of a claim, obtaining prior authorization for services, or resolving any legal or administrative issues as directed by me.
- I understand that I may revoke this authorization at any time by notifying MCH in writing. I understand that any revocation shall not be effective to the extent that action has already been taken in reliance on this Consent.
- I understand that all releases will expire when I am no longer an MCH patient.
- I understand that any information disclosed per this Authorization is subject to State and Federal Laws.
- I understand that any information disclosed per this Authorization may be re-disclosed by a recipient and no longer protected by Vermont or federal law.
- I understand that My treatment or payment for my treatment cannot be conditioned on the signing of this Authorization.

By signing this release, I acknowledge my permission to release the below information to and/or from the individual or agency I have named which may include drug abuse, alcohol abuse, behavioral health, and HIV information.

□ **All**	□ Only those items which are pertinent to _____referral
□ Office Notes	□ Test Results
□ Treatment Plan	□ Medications
□ Immunizations	□ Other_____

The date range of records to release (check one): □ Only documents from _____to_____ □ All dates

Reason for Request: _____ □ Transfer Out of MCH

Release of Information **TO**: _____

_____

I give permission to MCH to obtain copies of my PHI **FROM** the previous healthcare provider(s) listed below (address, phone, fax): _____

_____

The following family members, guardians, power of attorney, or executor (list name, address, relationship) may have access to my PHI (list medical and/or financial):_____

_____

_____	_____	_____
Signature of Patient or Patient's Representative	Printed Name	Relationship

Witness Signature/Printed Name_____ Date:_____

The confidentiality of substance use disorder patient records is protected by Federal regulations (42 CFR Part 2), which prohibit any person or entity named above from making further disclosure of this information unless such disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2.