Rutland Regional
Medical Center
160 Allen Street
Rutland, VT 05701

Date Received:_____ MR#_____

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

I hereby authorize Rutland Regional Medical Center to disclose my protected health information from my health record with no limitations placed on history of illness, or diagnostic and therapeutic information, including any treatment for alcohol or drug abuse, psychiatric impairments, HIV/AIDS related illnesses or genetic testing. I understand that authorizing the use or disclosure of the information identified below is voluntary. I need not sign this form to ensure healthcare treatment.

_____

Patient Name **Date of Birth**

_____

Address

Specific information to be released with dates of service: Abstract or Complete Copy (fee of $0.50/page)

_____ Emergency Department/Outpatient Date of Service:_____
_____ Inpatient: Date of Service:_____
_____ Discharge Summary
_____ History and Physical
_____ Operative Report
_____ Other _____

Information is to be released to:_____

Purpose of Disclosure: ❑ Own records ❑ Insurance Claim Other:_____

I understand that this authorization can be revoked in writing at any time. Written revocation must be delivered to Rutland Regional Medical Center Medical Records. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released. This authorization shall be valid for 1 year unless otherwise specified. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may not be subject to federal or state law protecting its confidentiality.

_____

Signature of Patient **Date of Signature**

_____

Relationship and/or authorizing if signed by person other than patient

_____

Signature of Witness **Date of Signature**

Release of future records must be limited in circumstances. For example: the patient must specify the types of information to be released. The signature of the patient is to be obtained unless patient is a minor or adjudged incompetent.
Processing time for a request is usually within 10 business days after the medical record is complete. Questions- Contact the Medical Information Secretary at 802.747.3654. FAX# 802.747.3656.
Please note: This material is available in alternate formats.

[Original – Other Provider] [Yellow – Requestor]

Request completed on _____/_____/_____ By:_____#Pages_____

Form #2716 07/02, 3/03, 5/03, 1/06, 4/06, 6/06