Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111

Date Received: _____
Request Log #: _____
MRN: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

I hereby authorize Rutland Regional Medical Center to disclose my protected health information from my legal 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.

*I understand that federal regulations (42CFR part 2) prohibit the disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations.

To release your medical information from Rutland Regional Medical Center, you must complete all sections of this form.

_____

Patient Name **Date of Birth**

_____

Address **Phone Number**

***There may be fees for copies of your records**

What is an abstract?
An abstract contains only the medical records needed by you and your providers to continue your care after discharge. This is what is released unless you ask for your **legal health record**. (The abstract usually includes: Discharge Summary, History & Physical, Lab, Pathology, Operative Reports, Procedure Notes, Radiology Reports, Problem List and Medications).

What is a legal health record?
In addition to what is in the abstract, your legal health record has all the information needed to identify you, support your diagnosis, justify your treatment, and document your care and results. This is a complete copy of your record.

Specific information to be released for dates of service: **Start** _____ **End** _____

❑ Abstract ❑ Billing Records

❑Test Results ❑ Legal Health Record

❑ Provider Notes ❑ Other: _____

Information is to be released to: _____
Recipient's Full Name and Address

Purpose of Disclosure: ❑ Own records ❑ Insurance Claim Other: _____
Desired Format: ❑ Paper ❑ Electronic Copy [PDF on Compact Disc (CD) or Thumb Drive, available for most records created after 3/1/2011]

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.
Expiration Date: _____

*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.
I understand that there may be fees for copying my legal health record. By signing below, I agree to pay these fees when I am billed for them by Rutland Regional Medical Center.

_____

Signature of Patient **Date/Time of Signature**

_____

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

_____

Signature of Witness **Date/Time of Signature**

Form #2716 Rev. 3/15, 5/15, 7/15, 9/15, 12/15, 2/16, 12/17, 8/18, 12/19

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.

Fulfilling a request requires individual review, and we strive to process a request within 10 business days after the legal health record is complete. RRMC processes requests on a first in, first out basis. HIPAA does allow 30 days to complete a legal health record request.

Questions?? Contact the Health Information Management/Release of Information office at 802.747.3654, Option 2
FAX# 802.747.3656, email rrmcmedicalrecords@rrmc.org. Office Hours: 8 a.m. – 4 p.m., Monday- Friday.

***What we will provide for a reasonable fee**
If you want your records sent to someone other than your doctor, you or the person receiving the records must agree to pay the fees. Here are the fees, based on Vermont Code Annotated 18 V.S.A. § 9419:

> **$6.50 flat fee for a disk or thumb drive copy** (available for most records created after 3/1/2011).
> **No charge for first 10 pages, $0.50 per page thereafter.**

If you would like to know in advance if the fee will be more than a certain amount, indicate this here:

Let me know if the fee for my records will be more than $_____.

Notify by phone or mail. Phone: _____

Requests will be processed upon receipt of payment.