



**THOMAS CHITTENDEN**  
HEALTH CENTER

**AUTO INSURANCE AUTHORIZATION**

Thomas Chittenden Health Center will submit a claim on your behalf to your auto insurance only if all of the required information below is complete. Please note that in the event your auto insurance declines the payment or has not responded to us within 45 days, you will be responsible for all related charges. In such a case, you may ask us to bill your health insurance.

**REQUIRED INFORMATION**

PATIENT NAME \_\_\_\_\_

DOB \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PRIMARY PHONE # \_\_\_\_\_ SECONDARY PHONE # \_\_\_\_\_

Date of injury \_\_\_\_\_

Description of injury \_\_\_\_\_

Auto Insurance Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Claim Number \_\_\_\_\_

Note: The release of medical records relative to auto insurance claim filed pursuant to Title 21 of the Vermont Statutes is not governed by the terms and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR 164.512 (1).

By signing below, you are authorizing Thomas Chittenden Health Center to release to your auto insurance company, adjustor, or employer ALL medical records you may have relating to the treatment or diagnosis of your injury. This includes history, findings, x-rays, bills, statements, diagnosis, lab reports and all other medical or hospital records in our possession including, but not limited to, records of treatment rendered by us as well as any medical records in our possession upon which we relied in any way in our treatment and/or diagnosis of your condition.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_