THOMAS CHITTENDEN
HEALTH CENTER

CONSENT TO DISCLOSE HEALTH INFORMATION

I, _____ DOB _____
(Name of **PATIENT** whose information is being requested)

Authorize _____
(Name and address of person/agency **SENDING** information)

To disclose to: _____
(Name and address of person/agency **RECEIVING** information)

The **PURPOSE** of this disclosure is: _____

PLEASE CHECK ALL INFORMATION YOU WOULD LIKE TO HAVE SHARED:

____ Entire Medical Health Record
Date range: ____ ALL - or - From _____ To _____

____ Please initial if you do **not** want to release protected psychiatric, psychotherapy, alcohol and/or substance abuse treatment notes.

Or specify records to be sent:

____ Office visit and progress notes
____ Labs/x-rays/EKG's/imaging reports
____ Immunization record
____ Thomas Chittenden mental health records
____ Thomas Chittenden substance abuse records
____ Outside records (i.e. consults from specialists, emergency room, hospital discharge, etc.)
____ Outside mental health records
____ Other:_____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

_____ _____
PRINT NAME **RELATIONSHIP TO PATIENT**

You are authorizing Thomas Chittenden Health Center to disclose records in the following formats: verbal, written, electronic. This consent will expire one year from date signed. Transfer of records to another doctor office provided at no charge. Records provided to patient at cost of .50 cents a page.

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