AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME_____ DATE OF BIRTH ____/____/____

[_____] Records <u>TO UVP</u>: I hereby authorize _____

_____

[provide address if known and/or Phone #_____ Fax #_____] to disclose to Upper Valley Pediatrics at 331 Upper Plain, Bradford, VT 05033 Phone# 802-222-4722 / Fax# **866-359-0233** the specific information indicated below and for the purpose(s) indicated below.

[_____] Records <u>FROM UVP</u>: I hereby authorize Upper Valley Pediatrics to disclose the information indicated below and for the purpose(s) indicated below TO: _____

_____

[provide address if known and/or Phone #_____ Fax #_____]

Federal Law protects certain sensitive information from release without specific authorization. I hereby consent to the release of records related to the following indicated, by means of written &/or oral disclosure:

****PLEASE INCLUDE:** (records released FROM UVP will include the following)

(1) Immunization Record(s)

(2) Health Information Summary which includes a problem list, allergies, medication history, immunization history, laboratory reports and any screening studies done

(3) Growth Charts – height or length, weight & BMI

(4) Patient's most recent **annual well** visit and if the patient is on any mental health or psychotropic medications, a **copy of the most recent medication check visit**.

This information is being requested for the following purpose(s):

_____**Patient Transferring Care** _____Appointment/Service Planning & Coordination

- I understand that it is the policy of Upper Valley Pediatrics to transfer records to another Primary Care Physician one time at no charge, additional requests for copies from other entities will be assessed a minimum fee of $15.00.
- I understand that Drug & Alcohol Information as well as AIDS/HIV information may be disclosed if it is contained in my record. I understand that I have the right to restrict this information should I choose.
- I understand that federal regulations (42 CRF part 2) prohibit the disclosure of drug & alcohol treatment information without my written consent or as allowed by the regulations I understand that under Vermont statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule (Privacy Standards of the Health Insurance Portability and Accountability Act of 1996.
- I understand that my treatment/support is not conditioned upon authorizing this disclosure. I understand I may revoke this authorization at any time except to the extent that any agency making the disclosure, has already acted in reliance on it. In general revocation of this authorization should be submitted in writing to the entities indicated.
- Any questions regarding the transfer of records should be addressed to the records dept of the Bradford office at 802-222-4722.

Printed Name _____ Relationship to Patient(s)_____

Signature _____ Date_____