COPLEY HOSPITAL

Medical Record Number _____

Protected Health Information Release Authorization

528 Washington Highway
Morrisville, VT 05661

Full Name: _____ Date of Birth: _____

Address: _____

_____ Phone Number: _____

I authorize Copley Hospital to use/disclose my protected health information to _____

Address: _____

_____ Phone Number: _____

for the following purpose: ____ Own records ____ Insurance Claim ____ Other

_____ Complete copy of medical record
_____ Psychotherapy Notes Only (If applicable, no other information may be included in authorization)
_____ Other (describe)
_____
_____

Information released by: ___H.I.M. Dept. ___ER Dept. ___Other (specify) _____

Dates of care included: From_____ to _____

The information authorized for disclosure may relate to: [check all that apply]:

_____ Mental illness (excluding psychotherapy notes) _____ HIV related illness _____ AIDS
_____ Drug or alcohol treatment (further re-disclosure prohibited or governed by 42 CFR Part 2)

☐ I understand that I may inspect or copy the protected health information described by this authorization.

☐ I understand that this authorization may be revoked in writing and delivered to the Health Information Management Department of Copley Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

☐ I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ I understand that I may refuse authorization to release all or some health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.

_____ _____ _____

Date Signature of individual or representative [Authority or relationship of representative]

* * * *

EXPIRATION DATE: This authorization will expire on [date or event] _____.
(If no date or event is stated, expiration is six months from the date it was signed.)

COPY PROVIDED: Copley Hospital shall provide a copy of this authorization, when signed, to the subject individual.

Copley Hospital Health Information Department Phone: (802)888-8269 Fax: (802)888-8361

Date copied:_____ Initials:_____ Number of Pages:_____

Revised 10/2008/form 1085 revised 02/2017