Patient Request for Health Information Authorization Form

MR#_____

COPLEY

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below): Date(s) of Service: ____/____/_____ through ____/____/____

☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports ☐ Billing Records ☐ Physical Therapy/OT

☐ Complete Record ☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐ Other (Progress Notes, Medication Lists) Please specify: _____

How would you like your records delivered? ☐ In-Person Pickup ☐ Mail Delivery ☐ Fax ☐ Pt Portal

What format? ☐ Paper Copy ☐ Electronic Copy (E-mail, USB, CD, Access in pt portal, Other)

Many documents that you may be requesting are available to you in your patient portal.

Please specify: _____

I authorize Copley Hospital to: ☐ Provide a copy of my records to: ☐ Me
☐ Release my Records:

TO: _____
(Name of Healthcare Practitioner/Facility/Other)

_____
(Street Address)

_____
(City, State, Zip) (Fax Number) (Phone Number)

Purpose of Release:_____

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or an earlier date is specified here: ____/_____/_____.
- I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation request, by mailing or faxing my written request to revoke to: **Copley Hospital HIM, 528 Washington Hwy, Morrisville VT 05661**
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse.

Signature of Patient Only: _____ Date: _____/_____/_____

If you are NOT the patient but are signing on behalf of the patient, please complete below
I, _____, am the (check which applies)
☐ Parent with Parental Rights ☐ Court Appointed Guardian ☐ Legally Appointed Healthcare Agent
☐ Medical Power of Attorney ☐ Court Appointed Personal Representative of Deceased
Representative's Signature: _____ Date: _____/_____/_____ (Required)
Address: _____ Phone: _____
You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent)

Form 1085 (06-21)

HIM Phone Number: (802)-888-8269 HIM Fax Number: (802)-888-8361
Date Copied_____/_____/_____ Initials:_____ Number of Pages:_____ MR #_____