



## AUTHORIZATION TO SEND HEALTH INFORMATION

Fax Medical Records to: (802) 453-6105 Email Dental Records to: [info-dental@mchvt.org](mailto:info-dental@mchvt.org)

This form allows MHC to verbally communicate with the authorized person or organization listed below.

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Information REQUESTED FROM: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Information RELEASED TO: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Reason for Release: Please choose the reason(s) for the release of your information:

- Coordination of care
- Transfer out of practice
- Other (please describe): \_\_\_\_\_
- Legal purposes

### Please choose all information you would like to have shared:

#### Medical:

- HEALTH RECORD - This includes past medical records from outside agencies that MCH has on file.

Date range: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ If no dates are specified, all records of this type selected will be shared.

- Other (test results, appointments, billing information, etc. Please describe): \_\_\_\_\_

#### Behavioral Health:

- Complete Behavioral Health/Therapy Record

Date range: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ If no dates are specified, all records of this type selected will be shared.

- Other (please describe): \_\_\_\_\_

#### Dental:

- Dental x-rays – All
- Other (appointments, billing information, etc. Please describe): \_\_\_\_\_

### I understand that information released may include medical, mental health and/or drug and alcohol records.

I understand that my Medical Records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by state and federal regulations. A photocopy or facsimile of this consent is valid as is the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. You are authorizing Mountain Community Health to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent, Guardian, or Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Describe authority to sign on behalf of patient: \_\_\_\_\_ Contact number: \_\_\_\_\_

I understand that I may revoke this consent at any time. My decision to revoke this consent will not affect the records that were previously released under this consent. I hereby revoke this consent on: \_\_\_\_\_ (date). Do not release any further information under this consent.  
Signature: \_\_\_\_\_