

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

BY SIGNING THIS FORM, YOU AUTHORIZE CHAMPLAIN VALLEY PHYSICIANS HOSPITAL OR ITS AGENTS TO RELEASE OR OBTAIN YOUR HEALTH INFORMATION TO THE PARTIES LISTED ON PAGE 2. PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY RELEASE.

**Section A:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_

State & Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Section B: Reason for Release of Information:**

|   |  |  |  |                                  |
|---|--|--|--|----------------------------------|
| <input type="checkbox"/> Medical Care               | <input type="checkbox"/> Personal Records  | <input type="checkbox"/> Insurance/Payment | <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> School: |
| <input type="checkbox"/> Attorney/Legal Proceedings | <input type="checkbox"/> Provider Transfer | <input type="checkbox"/> Disability        | <input type="checkbox"/> Other:                |                                  |

**Section C: Party to Receive or Disclose Information:**

- Release a copy of my protected health information (PHI) to me.
- Release/disclose my PHI to:

|   |                   |
|---|-------------------|
| Name: _____   |                   |
| Address: _____  |                   |
| Phone Number: _____   | Fax Number: _____ |
| Delivery Method : <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Secure portal (Please provide email address to receive link:<br><input type="checkbox"/> E-mail address: _____ (only for patients, patient guardian(s), or next of kin for deceased patients).<br><input type="checkbox"/> Other: _____ |                   |
| <b>Please note that if the request is for an unencrypted electronic delivery method, it may not be secure. The requester acknowledges and accepts risk associated with unencrypted electronic transmission. It is the recipient's responsibility to protect the information once received.</b>  |                   |

**Section D: Description of the Information to be released:**

The date of service and type(s) of information to be used or disclosed are as follows:

The records to be released will cover the time period from \_\_\_\_\_ to \_\_\_\_\_

Records from a specific Provider/Clinic: \_\_\_\_\_

- Discharge Summary
- Emergency Dept. Notes
- Cardiology Testing Reports
- Billing
- Inpatient Notes
- Laboratory/Pathology Reports
- Radiology Reports
- Immunizations
- Office or Clinic Notes
- Operative Reports
- Radiology Images
- History and Physical
- Consults

Other: \_\_\_\_\_

