

**TOTAL HEALTH CENTER
MARLBORO COLLEGE
MARLBORO, VERMONT 05344
Ph: 802-258-9335; Fax: 802-251-7604**

AUTHORIZATION TO EXCHANGE MEDICAL INFORMATION

Name: _____ D.O.B. _____

For the purpose stated below, and under the conditions designated on this form, I hereby authorize the Total Health Center to:

Release my health information to, OR Obtain my health information from

DETAILS OF REQUEST

Dates of Service: From _____ To _____

Information Requested:

- | | |
|---|---|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Evaluation Reports |
| <input type="checkbox"/> Counseling/Psychological Reports | <input type="checkbox"/> Referral letters |
| <input type="checkbox"/> Test Results | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Outpatient Summaries | <input type="checkbox"/> Physical Exam |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Information re: Legal Issues |
| <input type="checkbox"/> Other _____ | |

Purpose for Disclosure:

- | | |
|---|--|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Insurance Claim |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Legal Matter |
| <input type="checkbox"/> Other _____ | |

REVOCAION, REDISCLOSURE AND CONDITIONING OF ELIGIBILITY

I understand that authorizing the disclosure of information identified above is voluntary, and this authorization is not intended to alter my ability to receive medical care from any health care provider. I understand that I have the right to review this information before it is released.

I understand that this authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on it. Revocations must be made in writing to the Total Health Center.

I understand that further disclosure of the information to be disclosed may not be made without my written authorization or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment and Patient Records).

Note: This authorization for release of health information (unless expressly revoked earlier) expires six (6) months after the date signed.

SIGNATURE

Date: _____ Signature: _____

Date: _____ Witness: _____

IMPORTANT NOTICE

The federal privacy bill, the Health Insurance Portability and Accountability Act (HIPAA), has had a significant effect on the process for requesting copies of patient medical records.

The HIPAA rule (Section 164.508) pertaining to the release of protected health information states that an authorization for the release for medical records **MUST** be in plain language and contain the following elements to be valid:

- Identification of persons or class of persons authorized to make disclosure
- Identification of persons or class of persons to whom the physician practice is authorized to make the disclosure
- A description of the health information to be disclosed, including dates of service
- A description of the purpose of the use of the health information
- The Patient's signature and date

The Authorization for release of information is not valid, according to HIPAA statute, if the authorization has any of the following defects:

- The expiration date has passed
- The authorization has not been filled out completely with respect to the required content listed above
- The authorization is known by the physician practice to have been revoked
- Any material information in the authorization is known by the physician practice to be false

FEDERAL REGULATION (42 CFR, Part 2)

This information may have been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute the patient.