NEW ENGLAND MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

_____ _____

Patient Name **Date of Birth**

Medical Record #: _____ **Account #**: _____

1. I hereby authorize _____ to:
   - ____ obtain my information from:
   - ____ release my information to:

_____

Name

_____

Street Address

_____

City, State, Zip Code

2. Information to be released: Treatment Dates: _____

____ History & Physical Examination	____ Physician Orders
____ Discharge Summary	____ Laboratory Reports
____ Diagnostic Imaging Report	___ EKG/Cardiology Reports
____ Emergency Department Report	____ Operative Reports
____ Pathology Reports	____ Progress Notes
____ Rehab Reports (PT/OT/SLP)	____ Digital Images

Digital Images created by _____

Other (specify): _____

3. **There are no limitations** placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol, drug, HIV/AIDS, mental health, behavioral health or psychiatric and/or psychotherapy notes or treatment.

THE SIGNER MUST INITIAL THIS CLAUSE: _____ OR QUALIFY #3 ABOVE

4. The above information is released for the following purpose and that purpose only.

____ Continuation of Care	____ Legal Purposes
____ Insurance Purposes	____ Employer Requirement
____ Personal Reason	
____ Worker's Compensation	____ Other: _____

Revocation Process: I understand that I must place my request in writing to the Privacy Officer; I can revoke this authorization at any time. However, I understand that a health care organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy.

Continue on reverse 

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This authorization **will expire one (1) year from the date of my signature** or as otherwise specified by date, event or condition as follows:

_____ .

5. **Right to Copy/Voluntary Disclosure:** I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

6. **Health Plan/Insurance Issuers-Conditions:** I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, enrollment in a health plan, eligibility for its benefits or if I am authorizing my information to be released to an insurance company. I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization,

7. **Photocopy:** I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that Northern Vermont Dermatology may deny the release of protected health information if it has reason to believe:

(1) this authorization has been altered or

(2) is not a true and accurate authorization initiated by the patient.

REDISCLOSURE: I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential of unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

SIGNER MUST INITIAL THIS CLAUSE: _____

_____ _____

Patient's Signature **Date**

(Photo identification or verification of signature is required)

_____ _____

Signature of Legal Representative/Relationship to Patient **Date**

(Photo identification may be required)

_____

Department Use Only:

Requires Supporting Document to Prove Authority to Act on behalf of Patient — Please Attach.

☐ Photo ID from patient/legal representative verified

Information released per authorization by: _____ on date: _____