Brookside Family Health Center

PO Box 416, Hinesburg, VT 05461
Tel: 802-482-3900

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

General Information Regarding This Authorization

This Authorization permits the Brookside Family Health Center (the "Health Center") to use or disclose your Protected Health Information for purposes other than your treatment, payment to the Health Center or the health care operations of the Health Center. You have the right to revoke this Authorization by providing the Health Center with written notice of revocation. The revocation will be effective upon receipt by the Health Center except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.

The Health Center cannot require you to sign this Authorization as a condition to the provision of services.

Please note that once the requested information is disclosed pursuant to this Authorization, the Health Center will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

Authorization

I hereby authorize the Health Center or any of its staff to use or to disclose, by any acceptable means, including fax or email, my Protected Health Information described as follows

_____
_____
_____
_____

To the following persons or class of persons (include name, address and telephone number)

_____
_____
_____
_____

The purpose of this requested use or disclosure is

_____

This Authorization shall expire on _____, 20_ _, which is not more than one year after its effective date, unless it is revoked prior to the expiration date.

If applicable, please initial the appropriate blank in the following statements:

1. Alcohol or Drug Treatment Records: I do_____/I do not_____ authorize the use of disclosure of drug or alcohol abuse treatment records. I understand that these records are protected under federal regulations (42 CFR Part 2). I understand that I have the right to refuse to release this information. [Send 42 CFR Part 2 advisory with record.]

2. HIV Status: I do_____/I do not_____ authorize the release of HIV test results for the purpose set forth above.

_____ _____
Signature of Patient or Legal Representative Date Signed

_____ _____
Print Patient Name Date of Birth

_____ _____
Print Name of Legal Representative & Relationship to Patient