AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ Date Of Birth _____

I Authorize Previous Health Care Provider _____

Location / Address Of Previous Health Care Provider _____

Telephone / Facsimile Number _____

To release any and all information regarding the following types of health records, services, treatment, care and the types of medical conditions associated with the above-named patient. The information to be released may include information related to Hepatitis, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing, behavioral or mental health services, and treatment of alcohol or drug abuse to:

Appletree Bay Primary Care located at 1205 North Avenue, Burlington, Vermont 05408
Telephone: (802)863-1313 **Fax: (802) 863-2396**

____ ONLY Medication Prescribed, Test Results, Immunization, Present Problem Information, Allergies, Last Physical Notes

SEND RECORDS VIA FAX IF UNDER 30 PAGES **OTHERWISE PLEASE MAIL TO ADDRESS LISTED ABOVE**

Signature of Patient / Authorized Representative _____

Date _____

I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing addressed to: Appletree Bay Primary Care, 1205 North Avenue, Burlington, Vermont 05408

Expiration of Authorization
I understand that this authorization will expire on _____ (insert expiration date). If I do not specify an expiration date, this authorization will expire 1 year from the date I signed this authorization.

Signature of Witness _____ Date _____

Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law. This release applies to any individually identifiable health information (Protected Health Care Information) governed and protected by the Health Insurance Portability and Accounting Act of 1996 (HIPPA) as amended and under the rules and regulations thereunder.