RELEASE OF HEALTH INFORMATION

Patient Name _____   Date of Birth _____

I Authorize:
Name of Previous Health Care Provider   _____

Address of Previous Health Care Provider   _____

_____

Fax Number _____   Telephone 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.

_____ ONLY Medication Prescribed, Test Results, Immunizations, Problem List, Allergies, Last Physical

SEND RECORDS VIA FAX IF UNDER 30 PAGES - IF OVER 30 PLEASE MAIL TO ADDRESS LISTED BELOW

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

Signature of Patient /Authorized Representative_____

Date _____

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.

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

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