1 Anna Marsh Lane
PO Box 803
Brattleboro, VT 05302

Brattleboro Retreat
COMPREHENSIVE MENTAL HEALTH SERVICES SINCE 1834

Main Phone # 802-258-3728
Records Fax # 802-258-3792
Records Email: records@brattlebororetreat.org

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth _____

If authorization relates to active treatment, it will become null and void upon patient discharge.

I hereby authorize the Brattleboro Retreat to:

☐ **Release Information to:** ☐ **Obtain Information from:** ☐ **Exchange Information during treatment with:**

INDIVIDUAL OR INSTITUTION	☐ SELF ☐ COUNSELOR ☐ PSYCHIATRIST ☐ PHYSICIAN ☐ THERAPIST ☐ FAMILY MEMBER ☐ PROBATION /PAROLE OFFICER ☐ HOSPITAL ☐ AGENCY (DCYF, SRS, etc.) ☐ EMERGENCY CONTACT ☐ OTHER (Specify):
ORGANIZATION	
STREET **TOWN/STATE/ZIP** **PHONE#** **FAX#**	

PLEASE NOTE: THIS AUTHORIZATION IS ONLY VALID WHEN ALL SECTIONS BELOW ARE COMPLETELY FILLED OUT.
THANK YOU FOR YOUR COOPERATION.

What were the dates of treatment? From: _____ to _____

Requested Information: (Please check ALL that apply)

( ) Discharge Summary (chief complaint, hospitalization summary, diagnosis, condition on discharge, prognosis, & medications)
( ) Record Abstract (includes: discharge summary, initial assessment, psychosocial assessment, physical exam)
( ) Medications ( ) Provider progress notes ( ) Test Results/Labs
( ) Physical Exam ( ) Other (specify)_____

Purpose or need for this request (Please check one)

( ) Continuation of Care ( ) Insurance Claim/Application ( ) Attorney/Legal Matter
( ) Social Security/Disability ( ) Personal use ( ) Other (specify) _____

I understand that my records may contain information regarding treatment for drug and/or alcohol abuse, psychiatric treatment or other sensitive information and agree to the release of this information. **I understand** that further release of the information may not be made without my written authorization or as otherwise restricted by Federal Regulations (42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment and patient records.) I also hereby release the Brattleboro Retreat of any liability if the disclosed information is re-released by the recipient. Any authorizations to release information relating to HIV test results or infection must be specifically stated so in the "Other (specify)" section listed above prior to release.

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 expires **twelve (12)** months from the date signed and can be revoked at any time except to the extent that disclosure made in good faith has already occurred. Revocations must be made in writing to: Brattleboro Retreat, Attn: Health Information Management Department, 1 Anna Marsh Lane, and P.O. Box 803, Brattleboro, VT 05302. Any information that is generated *after* the date of discharge from the hospital cannot be released until an updated authorization is received.

( ) **I understand** that according to Vermont state law; **Title 18 V.S.A. § 9419** there can be a charge for records of either 50 cents per page or 5.00 whichever is greater. Please place a checkmark to acknowledge your understanding.

_____ _____
***PATIENT SIGNATURE** ***DATE**

_____ _____ _____
Guardian OR Parent signature **Relationship to patient** **Please print name**

This authorization (and any revocation) must be signed by the patient if the patient is = to or > 14 years of age.

Revised 2/24