Brattleboro Retreat
We'll help you find the strength.

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

1 Anna Marsh Lane
PO Box 803
Brattleboro, VT 05302

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth_____

I hereby authorize the Brattleboro Retreat to:

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

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

NOTE: THIS AUTHORIZATION IS NOT VALID UNLESS ALL SECTIONS BELOW ARE COMPLETELY FILLED OUT. IF INCOMPLETE, IT WILL BE RETURNED TO YOU. THANK YOU FOR YOUR COOPERATION.

What were the dates of treatment? (Be specific) From:_____ to _____

Requested Information:

( ) Discharge Summary (chief complaint, hospitalization summary, diagnosis, condition on discharge, prognosis, & medications)

( ) Medications ( ) Provide therapy session hospital notes* ( ) AIDS/HIV
( ) Test Results/Labs ( ) Other (specify)_____
( ) Physical Exam *please contact your provider or therapist for individual session office notes

Purpose or need for this request (Must 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 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 **six (6)** 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 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 checked in the above box, prior to release.

( ) **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.

( ) I have read and understood the HIPAA Notice of Privacy Practices attached to this authorization form. 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.

Updated 8/2021