Consent to Release Information

I _____(name), born on_____

phone:_____ , authorize

Community Health Centers of Burlington
617 Riverside Avenue Burlington, VT 5401
Phone# 802-864-6309 Fax 802-860-4313

To disclose to: Winooski Integrative Medicine PC
321 Main St. Suite B, Winooski VT, 05404
Do Not Mail Records
Fax records to: 833-464-3117

The purpose of the disclosure is for:

- ☐ Transfer care
- ☐ Consultation
- ☐ Other: _____

Please check all information you would like to have shared:

Medical Information to Disclose			
	Entire Medical Record		Past 1 year of office visit notes
	Problem list		Treatment Plans
	Medication List		Test Results
	Surgical History		Immunizations
	Allergy List		Family History
	Other:		

Time period or other specifics related to the information to be disclosed

- ☐ From _____ to _____ Or
- ☐ All past, present, and future periods
- ☐ The date of the document signature until the following event:
  _____

You are authorizing Winooski Integrative Medicine to disclose your records in the following formats: written, verbal, electronic, unless otherwise specified here:_____

I understand that information released may include information related to (check all that apply):

- ☐ Medical
- ☐ Psychiatric/ mental health
- ☐ Hepatitis
- ☐ Sexually transmitted diseases
- ☐ HIV and AIDS
- ☐ Genetic testing
- ☐ Treatment of alcohol or drug abuse

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164, unless otherwise provided for by the regulations.

I also understand that I may revoke this consent at any time by notifying us in writing of my desire to do so except to the extent that action has been taken in reliance on it before I revoked it.

A photocopy or facsimile of this consent is as valid as the original.

I understand there are limited circumstance where I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations.

Date or event upon which this consent will expire _____

I understand if I do not state a date or event, then this consent will expire one year from the last date of service to me at Winooski Integrative Medicine PC

Your signature on this authorization indicates that you understand the information disclosed under this authorization form and may be re-disclosed by the receiving person(s) or facility and would then no longer be protected by federal privacy regulations.

☐ I waive my right to review my medical records before they are released.

Signature:_____ Date:_____

Legal Representative Printed Name:_____

Legal Representative relationship: _____