LITTLE RIVERS HEALTH CARE

AUTHORIZATION FOR RELEASE OF INFORMATION
HIPAA COMPLIANT RELEASE

Patient's Name:_____ DOB: _____
From:
Facility/Provider:_____

Address/Phone:_____

To*:* **Little Rivers Health Care, Maegan – New Patient Coordinator, 437 S. Main St, PO Box 318 Bradford VT 05033**

phone 802-222-3025 fax 866-939-1476___

I hereby authorize and request the exchange of information between Little Rivers Health Care and the above named individual/organization. The following information is requested to be shared:

☐ **All**	☐ **Only those items which are pertinent to this referral**	
☐ Office Notes	☐ Intake Assessment	☐ Test Results
☐ Psych/Social/Emotional Evaluation	☐ Medications	☐ Treatment Plan
☐ Immunizations	☐ Summaries	☐ Discharge Summary
☐ Counselor Reports	☐ Teacher Reports	

Date range of records to release (check one): ☐ Only documents from _____to_____ ☐ All dates

Reason for Request_____

Form of Disclosure (check all allowed): ☐ Written ☐ Verbal ☐ Electronic

- Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

- I understand I may revoke this authorization at any time by notifying LITTLE RIVERS HEALTH CARE in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand I have a right to request and receive a **Notice of Privacy Practices** for LITTLE RIVERS HEALTH CARE, INC.
- All releases expire one year from the date signed unless otherwise indicated. Optional expiration date: _____
- I hereby authorized the following; (please initial if applicable)

_____Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune-Deficiency Syndrome).

_____	_____	_____
Signature of Patient or Patient's Representative	Printed Name	Relationship

Witness Signature/Printed Name_____ Date:_____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release