University of Vermont | Center for Health and Wellbeing

Athletic Medicine/Counseling and Psychiatry (CAPS)/ Nutrition/Student Health Services
Telephone: 802-656-3303 Fax: 802-656-8001
Medical Records Mailing Address: 425 Pearl Street Burlington, VT 05401

Authorization for Release of Protected Health Information

Patient Name: _____ **D.O.B:** _____
(last name) (first name) (middle initial)

Patient Phone Number: _____ **UVM Student ID:** _____

Patient Email: _____

I _____ (name of patient or representative) authorize the release, use or disclosure of the above named patient's protected health information between/to/from (selected) the identified below and the UVM Center for Health and Wellbeing.

☐ Provide information **BETWEEN** ☐ Provide information **TO:** ☐ Receive information **FROM**

_____ _____
Clinician Name/Parent or Guardian/Organization/Person *Email for Secure File Transfer*

*Phone*_____ _____ *Fax (Optional)*_____

Full Address: _____

The purpose(s) for which disclosure is authorized:

☐ Sharing with other health care providers ☐ For patient's personal records
☐ Other (please describe) _____ ☐ Sharing information with a trusted support person or parent

I authorize release, use or disclosure of following information (check all that are applicable):

☐ Entire Record ☐ Immunizations ☐ CAPS note(s) ☐ Most recent general physical exam
☐ All notes related to specific condition or issue (please specify): _____
☐ Lab results (please specify): _____ ☐ Other (please describe): _____
☐ Imaging reports (please specify CT, MRI, X-Ray, etc): _____

By signing I understand that:

I understand that the information to be released from my medical record may include sensitive information such as mental and behavioral health information, sexually transmitted infection information, and substance use disorder records.

I understand that I have the right to receive a copy of this Authorization and may revoke it at any time by submitting a written request; however, revocation will not apply to information already disclosed in reliance on this Authorization.

I understand that information disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws, except for substance use disorder records, which are protected by federal confidentiality rules (42 CFR Part 2). These rules prohibit further disclosure without my written consent unless otherwise permitted by law.

This Authorization is valid for the duration of my enrollment at the University of Vermont and will expire upon my graduation or following 1-year of separation from the University, unless I revoke it earlier in writing.

_____ _____ _____
Signature of patient or personal representative (e.g. legal guardian) ***Relationship to patient*** ***Date***

For office use: Records requested or released by: _____ Date: _____
(Medical Records Coordinator or other staff member)

Information sent via: ☐ Fax ☐ Email Secure File Transfer ☐ Mail ☐ Provided to patient on (date):