

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.

If you are an Alumni or currently unaffiliated with UVM, this authorization is valid for 1- year.

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

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|--|
| For office use: Records requested or released by: _____ Date: _____ <small>(Medical Records Coordinator or other staff member)</small> |
| Information sent via: <input type="checkbox"/> Fax <input type="checkbox"/> Email Secure File Transfer <input type="checkbox"/> Mail <input type="checkbox"/> Provided to patient on (date): _____ |