The University of Vermont
Center for Health & Wellbeing (CHWB)
Athletic Medicine/Counseling & 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: ______________________________________ **DOB:** ______/______/__________
Last name *First name* *Middle initial*

Phone number: ______________________ **UVM Student ID:**______________________________

I ______________________ (name of patient or representative) authorize the release, use or disclosure of the above named patient's protected health information.

☐ Provide information **To**: ☐ Receive information **From**: ☐ Provide information **Between** The University of Vermont, Center for Health & Wellbeing and:

______________________________ Clinician Name/Organization
______________________________ Street Address
______________________________ Phone Fax
______________________________ City/State/Zip Code

The purpose(s) for which disclosure is authorized:

☐ Sharing with other health care providers ☐ For patient's personal records
☐ Other (please describe) ______________________________

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): ______________________
☐ Specific visit/encounter note (please specify): ______________________
☐ Lab results (please specify): ______________________
☐ Imaging reports (please specify CT, MRI, X-Ray, etc.): ______________________
☐ Other (please describe): ______________________

I understand that:

Released records may include information related to: mental health counseling and behavioral health notes/sexually transmitted diseases/genetic testing including test results/Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), including, but not limited to, test results and the fact that a test was taken/and protected by 42CFR Part II, federal laws protecting alcohol and drug abuse records.

The Following limitations may apply: ______________________________
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I have the right to receive a copy of this Authorization, and may revoke the same at any time by providing a written notice of revocation. However, such revocation would not affect any action taken by Center for Health and Wellbeing in reliance on this Authorization, before receipt of my written revocation. The information released/disclosed by this Authorization, except information protected by federal regulations about the confidentiality of drug and alcohol abuse records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. ***Authorization to release this information is valid for 12 months from the date of signature on this release.*** Fees may be assessed for a copy of protected health information provided to me directly.

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

______________________________ ______________
Signature of witness: Date

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

Information sent via: ☐ Fax ______________ ☐ Mail ☐ Provided to patient on (date) ______________