Community Health Centers

FOR OFFICE USE ONLY

Verified by: _____

CONSENT TO DISCLOSE HEALTH INFORMATION

To send dental records - dentaltriage@chcb.org Medical Records - **Fax: (802) 860-4313**

File Only ☐ **Send/ Receive Records ☐**

I, _____ Date of birth:_____

(Name of **patient** whose information is being requested) (DOB of **patient**)

Authorize_____

Address: _____ Phone#_____ Fax_____

(Name, Address and Telephone # of person/agency sending information)

To disclose **to**:_____

Address: _____ Phone#_____ Fax_____

(Name, Address and Telephone # of person/agency receiving the disclosure)

Purpose of Disclosure: Please check ✓an option or list other reason.

Coordination of Care		Legal Purposes		Patient Copy	
2nd Opinion		Transfer Care		Other: Please Describe	

Please check all information you would like to have shared:

Medical Information to Disclose			
☐	ENTIRE MEDICAL HEALTH RECORD	☐	Information From My Therapy Chart
☐	Attendance	☐	Treatment Recommendations/Plan
☐	Medication Prescribed	☐	Treatment Progress Report
☐	Test Results	☐	HIV/AIDS Diagnosis/Treatment Information
☐	Diagnosis/Presenting Problem Information	☐	Discharge Summary
☐	Assessment Summary/Evaluation	☐	Other (please specify below):
☐	Appointments, prescriptions, test results	☐	Billing Information

Dental Information to Disclose			
☐	Dental X-Rays – All	☐	Other

Time period or other specifics related to the information to be disclosed (if none are specified, **all records** of the type(s) selected above will be shared): _____

You are authorizing The Community Health Centers of Burlington to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here_____.

I understand that information released may include medical, psychiatric, mental health, and/or drug and alcohol information. 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 Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time 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 that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Date or event upon which this consent will expire: I understand if I do not add a date_____ or event_____, then this consent will expire one year from the last date of service to me at CHCB.

Patient Signature **Date**

_____ _____

Parent, Guardian, Legal Representative **Date**

_____ _____

Describe authority to sign on behalf of patient _____ **Contact Number:**_____

I hereby revoke this consent on_____(date). Do not release any further information under this consent.

Signature: _____

Regarding Information to be released:

Name of Person Whose Information is Being Requested: This is the name of the person to whom Community Health Centers of Burlington (CHCB) has provided services. If this person is a minor or under guardianship, put his or her name in this space. The parent or legal guardian will sign at the end of the consent.

Attendance: Means you are a patient at the CHCB. In some situations, CHCB will be confirming that you are attending treatment appointments.

Diagnosis/ Presenting Problem: Includes the problem for which you are being treated and may include the diagnosis name and/or code that goes with that problem.

Assessment Summary/Evaluation: May include a medical progress note or mental health or substance abuse assessment or summary of intake session.

Treatment Recommendations/Plan: May include how your medical provider plans to care for you. May include mental health or substance abuse treatment plan.

Medication Prescribed: Includes the medication list in chart or individual medications that you are taking.

HIV/AIDS Diagnosis/ Treatment Information: Any information related to HIV/AIDS status in your health record.

Treatment Progress Report: May include how you are doing working toward your health goals. May include progress in counseling or other mental health or substance abuse program.

Test Results: May include blood tests, urine drug screens, or other mental health or substance abuse screening. May include mental health or substance abuse screening tool results.

Discharge Summary: The summary of your course of treatment and results from your counseling appointments.

ENTIRE RECORD: Means there are no restrictions on what can be shared. If you check the box for ENTIRE RECORD, then everything in your chart (all other categories listed in these definitions) will be included in the disclosure.

- Entire record also includes the disclosure of all substance abuse information and information from my therapy chart.
- Entire record also includes past medical records from outside agencies.

Other: Please write specifically what you want disclosed if it is not included in the other categories above.

Time period or other specifics related to the information to be disclosed: Please indicate any limitations on the information disclosed, including information from a specific time period (dates) or regarding specific information or documents to be disclosed.

Purpose of Disclosure: By telling CHCB why you want this information disclosed, CHCB can ensure that only the minimum amount of information necessary to meet the purpose of your consent will be released. If you don't want to disclose the purpose, you can write "At the request of the patient" in this section.

Means of Disclosure: Health information can be relayed in different ways. CHCB needs to know in which format you wish to disclose it.

Date or event upon which this consent will expire: Unless you write a specific date or condition upon which this consent expires, it will expire automatically one year after your last date of service at CHCB.

Revoking Authorization: If you wish to revoke this Consent in the future, please come in and complete this section of your Consent or tell CHCB in writing that you no longer want to disclose this information. This revocation cannot be applied to information CHCB disclosed with your permission and prior to your revocation.