Community Health Centers

AUTHORIZATION TO SEND HEALTH INFORMATION

Fax Medical Records to: (802) 860-4313 Email Dental Records to: dentalxrays@chcb.org

This form allows CHC to verbally communicate with the authorized person or organization listed below.

Patient Name: _____ Date of birth: _____

Address: _____ Phone: _____

Reason for Release: Please choose the reason(s) for the release of your information:

- ☐ Coordination of care
- ☐ Transfer care
- ☐ Legal purposes
- ☐ Patient copy
- ☐ Second opinion
- ☐ Other (please describe):

Please choose all information you would like to have shared:

Medical:

- ☐ COMPLETE HEALTH RECORD - **This includes past medical records from outside agencies that CHC has on file.**

Date range: ___/___/____ to ___/___/_____ **If no dates are specified, all records of this type selected will be shared.**

- ☐ Other (test results, appointments, billing information, etc. Please describe):

Mental Health/Psychiatry:

- ☐ Complete Mental Health Therapy/Psychiatric Record

Date range: ___/___/____ to ___/___/_____ **If no dates are specified, all records of this type selected will be shared.**

- ☐ Other (please describe):

Dental:

- ☐ Dental x-rays – All
- ☐ Other (please describe):

Information REQUESTED FROM: _____

Address: _____

Phone: _____ Fax: _____

Information RELEASED TO: _____

Address: _____

Phone: _____ Fax: _____

Date or event upon which this consent will expire: _____

I understand that if I do not state a date of expiration above, then this consent will expire one year from the last date of service to me at CHC**. I understand that information released may include medical, psychiatric, mental health and/or drug and alcohol records.** I understand that my Medical Records are protected under 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 state and federal regulations. A photocopy or facsimile of this consent is valid as is 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. You are authorizing the Community Health Centers of Burlington to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here.

Patient Signature: _____ Date: _____

Parent, Guardian, or Legal Representative Signature: _____ Date: _____

Describe authority to sign on behalf of patient: _____ Contact number: _____

I understand that I may revoke this consent at any time. My decision to revoke this consent will not affect the records that were previously released under this consent. I hereby revoke this consent on: _____ (date). Do not release any further information under this consent.

Signature: _____

Revised November 2023