MR#______________

Springfield Medical Care Systems, Inc.

Information to be mailed to / sent from (check one):

□ **Springfield Hospital** (25 Ridgewood Rd, Springfield VT 05156) *ph - 802-885-7304 f-802-885-7389*	□ **Charlestown Family Medicine** (125 Main St. Charlestown, NH 03603) *ph – 603-826-5711 f-603-826-4659*	□ **Chester Family Medicine**, Ellsworth Mem. Health Ctr (Route 11, Main Street, Chester, VT 05143 *ph – 802-875-2546 f-802-875-2269*
□ **Ludlow Health Center** (1 Elm St., Ludlow, VT 05149) *ph – 802-228-8867 f-802-228-5170*	□ **Springfield Health Center** (100 River St. Springfield, VT 05156) *ph – 802-886-8900 f-802-885-5096*	□ **Rockingham Medical Group** (1 Hospital Court, Bellows Falls, VT 05101) *ph – 802-463-9000 f-802-463-3911*
□ **Connecticut Valley Orthopaedics** (29 Ridgewood Rd., Springfield VT 05156) *ph – 802-885-6373 f-802-885-6375*	□ **Surgical Associates** (29 Ridgewood Rd, Springfield, VT 05156) *ph – 802-885-5600 f-802-885-5605*	□ **The Women's Health Center** (29 Ridgewood Rd., Springfield, VT 05156) *ph – 802-886-3556 f-802-886-2535*
□ **Connecticut Valley ENT** (29 Ridgewood Rd., Springfield, VT 05156) *ph – 802-886-1775 f-802-886-1489*	□ **Springfield Urology** (29 Ridgewood Rd., Springfield VT 05156) *ph – 802-886-3556 f-802-886-2535*	□ **Mountain Valley Medical Clinic** 38 Rte 11, Londonderry, VT 05148 *ph – 802-824-6901 f-802-824-3602*

□ **Other**:________________________________

Protected Health Information Release Authorization

Full Name: ____ Date of Birth ____________________

This will authorize_________________________________. to □**use** □ **disclose** or □ **obtain** my protected health information for the following purpose (please circled): Continuity of Care Emergency Treatment Personal Use Legal Other___

To/From (person or facility)____

Information to be released (*please check*):

_____ ***Complete*** copy of medical record *** Dates of care included: ____________________to : ____________________

□ Discharge Summary (date) __________ □ Emergency Room Record (date) ___________ □ Operative Report (date) _________
□ History & Physical (date) ___________ □ Consultation (date) ____________ □ PFT, EKG, Stress, etc (date) ____________
□ Radiology report / CD / Film (date) ______________ □ Lab results (date) ___________
□ Other ________________________ (date) _____________

Route of delivery: □Paper copies □ Fax (**providers/hospitals ONLY**) □ CD

The information authorized for disclosure may relate to: (check all that apply):

_____ Psychotherapy Notes Only (If applicable, no other information may be included in authorization)
_____ Mental illness (excluding psychotherapy notes)
_____ Drug or alcohol treatment (further redisclosure prohibited or governed by 42 CFR Part 2)
_____ HIV related illness _____ AIDS

X I understand that I may inspect or copy the protected health information described by this authorization.

X I understand that this authorization may be revoked in writing and delivered to the appropriate Dept. of Springfield Medical Care Systems, Inc. at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

X I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

X I understand that Springfield Medical Care Systems, Inc. shall not condition treatment, payment, or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

X I understand that Springfield Medical Care Systems, Inc. shall have the opportunity to obtain direct or indirect remuneration in the nature of (describe): ____ from (third party) as a result of this authorization.

____
Date

____
Signature of individual or representative

____
Authority or relationship of representative

**** **** **** ****

EXPIRATION DATE: This authorization will expire on (date or event) ______________________________
(If no date or event is stated, expiration is twelve months from the date it was signed)

Incomplete or problem with transmission, or received in error, please call the above referenced/checked location.