Springfield Hospital & Springfield Medical Care Systems, Inc.
Authorization for use/disclosure of Protected Health Information (PHI)

Springfield Hospital Medical Records Department
25 Ridgewood Rd, Springfield, Vt. 05156
Phone: (802) 885-7304 Fax: (802) 885-7389

Patient:	DOB:	MR#:
Address:	Phone:	
City/State/Zip:	Email:	

This will authorize Springfield Hospital & Springfield Medical Care Systems, Inc. to use/disclose my individually identifiable health information as described below.

I hereby authorize/request from:	**To be released to:**
Name:	Name:
Address:	Address:
City & State:	City & State:
Zip:	Zip:
Phone:	Phone:
Email:	Email:

Purpose of the use/disclosure:

__Continuity of care __Legal __Emergency treatment __Transfer of care
__Personal use __Other_____

Please indicate the type of information you authorize for release:

__Discharge summary __History & Physical Exam __Emergency room records __Laboratory data/Pathology
__Operative note __X-ray, Scans, Etc. __Physician office notes __Behavioral Health notes
__Other_____ DATE **RANGE**_____**TO**_____

The information authorized for disclosure may relate to: Please check all that you **want** to be released:

___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 this authorization may be revoked in writing and delivered to the appropriate Dept. of Springfield Hospital & 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 Hospital & 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.

Date: _____ _____
Signature of individual or representative

_____
Authority or relationship of representative

I UNDERSTAND THIS AUTHORIZATION WILL EXPIRE 1 YEAR FROM THE DATE OF THIS AUTHORIZATION UNLESS I OTHERWISE SPECIFY AN ALTERNATE DATE_____

Updated 4/1/2020 K.R. HIM