Medical Records Release and Request

Medical Records Fax: (855) 247-1646
34 Bonnet Street
Manchester Center, Vermont 05255
Phone: (802) 768-1718

Patient Name:_____ DOB:_____/_____/_____

Mailing Address: _____

City:_____ State:_____ ZIP:_____

Home Phone:_____ Cell Phone:_____ Email: _____

By my signature below, I authorize Manchester Medical Center to **RELEASE** and/or **REQUEST** and obtain health records and information from the medical provider or healthcare facility listed below.

Health Records Requested From or Released To:

Doctor/Facility:_____ Specialty:_____

Address:_____ State:_____ ZIP: _____

Phone: _____ Fax:_____

Please specify the type of information that may be released:

- ☐ All Medical Records
- ☐ Medication History
- ☐ Vaccination Records
- ☐ Consult Notes
- ☐ Other (please specify)_____
- ☐ Laboratory/Pathology Reports
- ☐ Radiology/Imaging Reports
- ☐ Treatment Records

I request the above information be released. I understand that information released in my medical record may include information on drug and alcohol abuse, psychiatric impairments, AIDS/HIV related illnesses or genetic testing. I understand that I have the right to restrict this information should I choose. I understand that federal regulations (42 CFR part 2) prohibit the re-disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations. I understand that under VT statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures made to organizations outside of the State of VT, all other health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA. I understand this authorization is voluntary and can be revoked in writing at any time. A revocation must be submitted in writing to the address above. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released. NOTE: Once information has been disclosed, Manchester Medical Center can no longer protect it from further disclosure.

_____	_____	_____
Print Name of Patient	Signature of Patient or Authorized Signatory	Date