Anna Marsh Lane
P.O. Box 803
Brattleboro, VT 05302

Main Ph#: 802-257-7785
Records dept email: records@brattlebororetreat.org
Records Fax# 802-258-3792

Brattleboro Retreat
We'll help you find the strength.

Authorization to Use or Disclose Protected Health Information

Patient Name: _____Date of Birth_____

I hereby authorize the Brattleboro Retreat to:

☐ **Release Information to;** ☐ **Obtain Information from;** ☐ **Exchange Information during treatment with:**

INDIVIDUAL OR INSTITUTION	☐ THERAPIST ☐ COUNSELOR ☐ PSYCHIATRIST ☐ DOCTOR ☐ FAMILY MEMBER ☐ PROBATION/PAROLE OFFICER ☐ OTHER (SPECIFY):
ORGANIZATION	☐ FAMILY DOCTOR ☐ HOSPITAL ☐ AGENCY(DCYF, SRS, etc.) ☐ N/A ☐ FAMILY ☐ OTHER (Specify):
STREET **TOWN/STATE/ZIP**	**PHONE#** **FAX#**

Please sent information requested by the Brattleboro Retreat/Anna Marsh Clinic to the attention of:

Name:_____ Fax#_____

1. Requesting information for treatment dates: _____ to _____

   ( ) Discharge Summary (chief complaint, hospitalization summary, diagnosis, condition on discharge, prognosis & meds)
   ( ) Medications ( ) Emergency Contact ONLY
   ( ) Test Results/labs ( ) Other (specify)_____
   ( ) Physical Exam

2. Purpose or need for this request (Must check one)
   ( ) Continuation of Care ( ) Insurance Claim/Application ( ) Attorney/Legal Matter
   ( ) Social Security/Disability ( ) Personal use ( ) Other (specify) _____

I understand that my records may contain information regarding treatment for drug and/or alcohol abuse, psychiatric treatment or other sensitive information and agree to the release of this information.

I understand that authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter my ability to receive medical care from any health care provider. I understand that I have the right to review this information before it is released.

I understand that this authorization expires **six (6)** months from the date signed and can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance to it. Revocations must be made in writing to: Brattleboro Retreat, Attn: Health Information Management Department, Anna Marsh Lane, P.O. Box 803, Brattleboro, VT 05302. Any information that is generated *after* the date of discharge from the hospital cannot be released until an updated authorization is received.

I understand that further disclosure of the information to be disclosed may not be made without my written authorization or as otherwise restricted by Federal Regulations (42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment and Patient Records). I also hereby release the Brattleboro Retreat of any liability if the disclosed information is re-released by the recipient. Any authorizations to release information relating to HIV test results or infection status must specifically state so in the "Other (specify)" section listed above prior to disclosure.

This authorization is not valid if all sections above are not completely filled out.

Date _____/_____/_____ **Signature of Patient:**_____

If not signed by Patient, see Below

This Authorization (and any revocation) must be signed by the Patient if 14 years of age or older.

_____ _____ _____

Relationship to Patient | Signature of Parent/Guardian | Please Print Name