

**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 **Ludlow Health Center**(1 Elm St., Ludlow, VT 05149)  
ph - 802-228-8867 f-802-228-5170 **Connecticut Valley Orthopaedics**(29 Ridgewood Rd., Springfield VT 05156)  
ph - 802-885-6373 f-802-885-6375 **Connecticut Valley ENT**(29 Ridgewood Rd., Springfield VT 05156)  
ph - 802-886-1775 f-802-886-1489 **Charlestown Family Medicine**(125 Main St. Charlestown, NH 03603)  
ph - 603-826-5711 f-603-826-4659 **Springfield Health Center**(100 River St. Springfield, VT 05156)  
ph - 802-886-8900 \*\*Call for fax **Surgical Associates**(29 Ridgewood Rd, Springfield, VT 05156)  
ph - 802-885-5600 f-802-885-5605 **Chester Family Medicine, Ellsworth Mem. Health Ctr**(Route 11, Main Street, Chester, VT 05143)  
ph - 802-875-2546 f-802-875-2269 **Rockingham Medical Group**(1 Hospital Court, Bellows Falls, VT 05101)  
ph - 802-463-9000 f-802-463-3911 **The Women's Health Center**(29 Ridgewood Rd., Springfield, VT 05156)  
ph - 802-886-3556 f-886-2535 **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 \_\_\_\_\_

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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.**