TAMARACK FAMILY MEDICINE

PERMISSION TO SEND HEALTH INFORMATION TO TAMARACK FAMILY MEDICINE

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: ( )

Address: _____

City: State: Zip:

SENDER

I authorize:

Name of Provider: _____

Street Address: _____ Fax Number: ( )

City: State: Zip:

RECIPIENT

To share (disclose) my health information with:

Tamarack Family Medicine
109 Professional Drive
Morrisville, Vermont 05661
Phone: (802)-851-0999 Fax (877) 245-5990

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates:_____to _____

- ☐ All Records
- ☐ Progress Notes
- ☐ Prior Authorizations
- ☐ Hospital Admissions/Discharge
- ☐ Procedure Notes
- ☐ Advanced Directives
- ☐ Cardiac Studies
- ☐ Laboratory/Pathology reports
- ☐ Pulmonary & Spirometry Tests
- ☐ Consultation Notes
- ☐ Immunization Records
- ☐ Radiology Reports
- ☐ Diagnostic Imaging
- ☐ Other:_____

For the following purpose: _____

SENSITIVE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Tamarack Family Medicine <u>UNLESS I place my initials</u>** in the applicable space next to the type of records**:**

_____ Mental health treatment records
_____ Genetic testing
_____ HIV/AIDS test results
_____ Sexually Transmitted Disease (STD) treatment records
_____ Alcohol/drug abuse treatment records

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: Tamarack Family Medicine will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. Your sending health care provider may require fees to process your request.

SIGNATURE

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**

INSTRUCTIONS:
How to use "Permission to Send Health Information to Tamarack Family Medicine"

This form should be used when you want your health care provider to send your medical records to Tamarack Family Medicine.

PATIENT INFORMATION

Complete each box as indicated with the following information:

- Patient's name (please print clearly)
- Patient's date of birth
- Patient/Personal Representative's phone number
- Patient's mailing address, including City, State, and Zip Code

SENDER

Please fill in which health care provider you are authorizing to send your medical records:

- Provider's name or Provider's office/practice name
- Mailing address of the health care provider, including Street, City, State, and Zip Code
- Fax number of the health care provider's office

RECIPIENT

Tamarack Family Medicine's address has been pre-filled.

HEALTH INFORMATION TO BE SHARED

Fill in the date range that applies to the health information you are requesting to be sent.

Check the box(es) that describe the information you are requesting to be sent.

Fill in a description of the purpose of the requested records. Examples: Transfer to new provider, facilitate treatment, summarize treatment, etc. **This section must be completed in order for the form to be valid.**

SENSITIVE HEALTH INFORMATION

Depending on the state where your health care provider practices, additional laws and/or signature requirements may apply to releases of "sensitive" categories of health information. **If you do not place your initials in the spaces provided**, the health care provider may release such sensitive information as necessary to fulfill your request.

DURATION & REVOCATION

Your authorization will remain valid for one year from the date of your signature, unless you specify a different date in the space provided. You have the right to revoke your permission at any time. Note that your revocation will not apply to any previously released information. Please revoke by following the directions in the health care provider's Notice of Privacy Practices, or call the provider's office where your records are located.

ADDITIONAL INFORMATION

Please read this section on the form.

SIGNATURE

Sign and date the authorization.

If you are not the patient, describe your relationship and legal authority to sign on behalf of the patient. In some cases, you may be required to provide legal paperwork verifying your legal authority (e.g., court-appointed guardian, power of attorney for health care). Check with the sending health care provider's office regarding these requirements.