Maitri Health Care for Women
Obstetrics, Gynecology and Midwifery

FAX: 802-861-4236 P: 802-862-7338
185 Tilley Drive So Burlington, VT 05403

Authorization to Release Protected Health Information (PHI):

Patient Full Name: ____
DOB: ________________
Current Address/City/State/Zip:____

List any previous names: ______________ Phone: ______________________________

I authorize the use and disclosure of my health information as described below*, limit one form per provider/facility*:

☐ I give Maitri permission to OBTAIN my medical records **FROM:**

☐ I give Maitri permission to RELEASE my medical records **TO**:

Facility/Provider Name:
____

City/State:
____

Phone: _______________________________ **FAX:** _______________________________

Reason for Transfer of Records: ☐ coordination of care ☐ Transfer of Care ☐ Personal Record ☐ other, list:____________________

☐ I give permission for the receiving persons/organizations to send health information back to the providing persons/organizations (as in coordination of care).

I would like to release the following information **(check one):** ☐ Entire Medical Record ☐ Medical Record for the last 2 years ☐ Other (list specific records and/or date range):
____

☐ Restrictions: Do not release (specify records to exclude from release)____

PLEASE SIGN ON BACK

CONDITIONS OF AUTHORIZATION:

I understand that:

● If I refuse to release all or some of my health information, it may result in improper diagnosis or treatment, denial of coverage, or a claim for health benefits, or other insurance of other adverse consequences.

● The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), genetic testing, behavioral or mental health services, and treatment of alcohol or drug abuse.

● I may be charged a fee for copies of records in accordance with state and federal law. There is no fee for records faxed directly to another provider.

● I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing, and that my revocation will not apply to the information that has already been released in response to this authorization.

● Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law.

● Signing this form is voluntary. I do not need to sign this form to receive health care services at Maitri Healthcare

● This authorization will expire on _______________________. If I do not specify an expiration date, this authorization will expire one year from the date of signature.

PRINTED NAME: ____

PATIENT SIGNATURE: ____ DATE: _________________