CONSENT FOR RELEASE OF MEDICAL INFORMATION

Interventional Spine of Vermont

MAIL: 277 Blair Park Rd., Suite 110, Williston, VT 05495

PHONE: (802) 404-2004 FAX: (888)506-2885

I AUTHORIZE THE INTERVENTIONAL SPINE OF VERMONT TO RELEASE INFORMATION TO THE FOLLOWING ENTITY: _____

OR, I AUTHORIZE THE FOLLOWING ENTITY: _____
TO RELEASE INFORMATION TO THE INTERVENTIONAL SPINE OF VERMONT.

ADDRESS: _____

PHONE: _____ FAX: _____

PATIENT INFORMATION

PRINT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE CONTACT: _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT IF SIGNED BY LEGAL REPRESENTATIVE: _____

DATE: _____ THIS WILL EXPIRE 1 YEAR FROM DATE UNLESS SPECIFIED: _____

INFORMATION TO BE RELEASED

Put a checkmark next to the documents that apply to your request

___ CLINICAL NOTES (outpatient)	___ PROVIDER ORDERS	___ PROGRESS NOTES (inpatient)
___ EMERGENCY DEPT NOTES	___ NURSING NOTES	___ RADIOLOGY REPORTS
___URGENT CARE NOTES	___ CONSULTATIONS	___ PATIENT BILLING RECORDS
___ HISTORY and PHYSICAL	___ IMAGING REPORTS	___ LABORATORY REPORTS
___ DISCHARGE SUMMARY	___ ED NOTES	___ **ALL MEDICAL RECORDS**

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral as defined by federal law (42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.

PURPOSE OF THIS REQUEST

Put a checkmark next to the appropriate request

___ CONTINUED PATIENT CARE	___ ATTORNEY/LEGAL	___ INSURANCE
___ PERSONAL USE	___ SOCIAL SERVICE/DISABILITY	___ OTHER

FOR OFFICE USE ONLY

DATE RECIEVED: _____ DATE PROCESSED: _____

EMPLOYEE SIGNATURE:

_____