Avery Wood MD ☙ ❧ John Hearst MD

Family Medicine

Authorization to Release Medical Information

Patient Name:_____ Date of Birth:_____

I Authorize Information to be Released □ To: □ From:

Name of Facility:_____

Physician:_____

Address:_____

Phone:_____ Fax:_____

Please Send My Records □ To: □ From:

Avery Wood MD and John Hearst MD, PO Box 726, 10 Bank St. North Bennington, VT 05257

Phone: (888) 421-6801 Fax for Dr Hearst: 877-692-1063 Fax for Dr Wood: 877-796-4207

Purpose of Release:

□ Changing Primary Care Doctor to Dr Wood or Dr Hearst (please circle)

□ Other: _____

Type of Information to be Released

□ Entire Medical Record (including any sensitive information as described below)

□ A Summary of My Medical Record (which may include sensitive information as described below)

□ Specific Information Only:_____

Sensitive Information:

I am aware that my medical record may contain sensitive information including drug or alcohol abuse diagnosis and treatment; sexually transmitted diseases and HIV/Aids testing or treatment; mental health diagnosis and treatment; sexual identity, preferences and practices; genetic testing and family history. I am aware that if I wish to exclude this or other information from release, then Dr Wood or Dr Hearst will assist me in creating a release specific to my needs.

I am aware that my medical record may contain reports from other health care providers including members of the Community Health Team at Dr Wood and Dr Hearst's office and consultants from outside Dr Wood and Dr Hearst's office. These reports may also contain sensitive information as described above.

This authorization expires in one year. I may revoke this release at any time before this expiration by notifying Dr Wood or Dr Hearst. Information that is already in use for the purposes of treatment, payment or health care operations may not be retracted. I understand that once my medical information is released it may no longer be protected by privacy laws or by Dr Wood or Dr Hearst.

Patient Signature: _____ Date: _____

Signature of Legal Guardian: _____ Date:_____

Name of Legal Guardian: _____ Relationship:_____