Avery Wood MD ☙❧☙ John Hearst MD
Family Medicine

Authorization to Release Medical Information

Patient Name:_____ Date of Birth:_____

I authorize Wood and Hearst MD to release my medical information to:

Name of Facility:_____

Physician:_____

Address:_____

Phone:_____ Fax:_____

Purpose of Release:
□ Changing Primary Care Doctor

Type of Information to be Released
□ Entire Medical Record (including any sensitive information as described below)

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 one year from the date signed. 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.

Once completed, please send this release to Wood and Hearst MD
PO Box 726
North Bennington, VT 05257

Prior to 10/27/23 you may fax this release to 877-796-4207. After 10/27/23, please only mail.

Patient Signature: _____ Date: _____

Signature of Legal Guardian: _____ Date:_____

Name of Legal Guardian: _____ Relationship:_____