Avery Wood 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 PO Box 726 10 Bank St. North Bennington, VT 05257
Phone and Fax: (888) 421-6801

**Purpose of Release:**

☐ Changing Primary Care Doctor ☐ 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 Avery Wood MD will assist me in creating a release specific to my needs.

This authorization expires in 90 days. I may revoke this release at any time before this expiration by notifying Avery Wood MD. 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 Avery Wood MD.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Legal Guardian Date

_____ _____
Name of Legal Guardian Relationship to Patient