GREEN MOUNTAIN BREAST CARE CENTER

Authorization to Release Medical Records

166 South Main Street, Suite 1B, Stowe, VT 05672
Phone 802-441-5249 | Fax 949-890-4542

SEND RECORDS TO: Green Mountain Breast Care Center, Attn: Medical Records

FAX 949-890-4542 PHONE 802-441-5249

Mail: 166 South Main Street, Suite 1B, Stowe, VT 05672

PATIENT

PATIENT NAME (Last, First, Middle)	DATE OF BIRTH	PHONE
ADDRESS	NAME USED WHEN RECORDS WERE CREATED (if different)	LAST 4 OF SSN / MEMBER ID (optional)

RELEASE RECORDS FROM (list every facility or provider you want contacted)

I authorize the facilities and providers listed below to release my health information to **Green Mountain Breast Care Center and Sarah Waterman, MD, FACS** so that my care can be continued.

FACILITY / PROVIDER NAME	ADDRESS	PHONE	FAX
FACILITY / PROVIDER NAME	ADDRESS	PHONE	FAX
FACILITY / PROVIDER NAME	ADDRESS	PHONE	FAX
FACILITY / PROVIDER NAME	ADDRESS	PHONE	FAX

RECORDS TO BE RELEASED

☐ **RELEASE ALL RECORDS** (complete chart, including everything listed below; skip the individual boxes)

Or check only what you want released:

CLINIC / HOSPITAL	IMAGING AND PATHOLOGY	TREATMENT / OTHER
☐ Office visit / consultation notes	☐ Mammogram / ultrasound / MRI reports	☐ Oncology, chemotherapy and radiation records
☐ Hospital records, discharge summary	☐ Actual images (CD or electronic transfer)	☐ Surgical and reconstruction records
☐ Operative and procedure reports	☐ Pathology and biopsy reports	☐ Other: _____
☐ Medication and allergy lists	☐ Pathology slides / blocks (for review)	
☐ Laboratory results	☐ Genetic testing results	

Dates of service: ☐ All dates available ☐ From _____ to _____ ☐ Most recent 5 years

My records may include the following sensitive information. **Check each category you want released:**

☐ Mental health ☐ Substance use treatment ☐ HIV / STI ☐ Genetic testing ☐ Reproductive health

AUTHORIZATION

Purpose: continuing medical care. **Expiration:** this authorization expires one year from the date signed, or on _____ (date) if earlier. **Right to revoke:** I may revoke this authorization at any time by written notice to the facility releasing the records, except to the extent action has already been taken on it. **No conditions:** my treatment, payment, enrollment and eligibility for benefits do not depend on my signing this form. **Redisclosure:** information released may be redisclosed by the recipient and may no longer be protected by federal privacy rules. I may ask for a copy of this authorization.

PATIENT SIGNATURE	DATE	PRINTED NAME
If signed by a personal representative: name _____ relationship / authority _____		

GMBCC USE ONLY: Date requested _____ By _____ Records received _____ Scanned to chart ☐

CONFIDENTIALITY NOTICE: This document and any records transmitted with it contain protected health information intended only for the addressee. If received in error, call 802-441-5249 and destroy all copies.