RECORDS RELEASE AUTHORIZATION

TO: ____

(Doctor, Hospital or School)

____

Address and Telephone number

I hereby authorize and request you to share information with:

_______________________ (name of provider)

27 Rye Circle, South Burlington, VT 05403
Telephone (802) 654-7607
Fax (802) 654-9155

This protected information will be for the purposes of treatment, payment, or "healthcare operations" and may include the following activities:

- Payment
- Utilization Review
- Peer Review
- Quality Assurance
- Continuity of Care (disclosure to providers, healthcare facilities and others for treatment purposes)

I understand that my records are protected under the Federal Confidentiality Regulations, 42 CFR, part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I may revoke this consent at any time unless an action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event, this consent expires automatically one year after the date of my signature below.

The specified purpose(s) of this release include:

Requested information should be sure to include:

Name:	Date:
Signature:	Witness: