



Morrisville • Stowe • Newport • Vermont

555 Washington Highway
Morrisville, VT 05661

Protected Health Information Release Authorization

Mansfield Orthopaedics Medical Record Number _____

Full Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I authorize Mansfield Orthopaedics at Copley Hospital to use/disclose my protected health information to

Address: _____

Phone Number: _____

for the following purpose: ___ Own records ___ Insurance Claim ___ Other

___ Complete copy of medical record

___ Psychotherapy Notes Only (If applicable,
no other information may be included in
authorization)

___ Other (describe)

Information released by: ___ Mansfield Orthopaedics ___ ER Dept. ___ Other (specify) _____

Dates of care included: From _____ to _____

The information authorized for disclosure may relate to: [check all that apply]:

___ Mental illness (excluding psychotherapy notes) ___ HIV related illness ___ AIDS

___ Drug or alcohol treatment (further re-disclosure prohibited or governed by 42 CFR Part 2)

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that this authorization may be revoked in writing and delivered to Mansfield Orthopaedics at Copley Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that the Mansfield Orthopaedics at Copley Hospital shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

Date Signature of individual or representative [Authority or relationship of representative]

* * * *

EXPIRATION DATE: This authorization will expire on [date or event] _____.

(If no date or event is stated, expiration is six months from the date it was signed.)

COPY PROVIDED: Mansfield Orthopaedics shall provide a copy of this authorization, when signed, to the subject individual.

Mansfield Orthopaedics Phone: (802)888-8405 Fax: (802)888-406

Date copied: _____ Initials: _____ Number of Pages: _____