Vineyard Medical Care

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ **Date of Birth**: _____

Previous Name: _____ **Social Security #**: _____

☐ REQUEST (OBTAIN) INFORMATION	☐ RELEASE (SEND) INFORMATION
I authorize Vineyard Medical Care to **request** healthcare information of the patient named above from: **Name/Facility:** _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____ **Fax:** _____ **Please Send Records To:** **Vineyard Medical Care** **364 State Road** **Vineyard Haven, MA 02568** **Phone: 508-693-4400 Fax: 508-693-2098**	I request and authorize Vineyard Medical Care to **release** healthcare information of the patient named above to: **CHOOSE ONE** ☐ Myself, I will pick up my records ☐ Please send to: **Name/Facility:** _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____ **Fax:** _____

This request and authorization applies to:

☐ Verbal communication and/or written updates between both facilties

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

Reason for request:

☐ Coordination of Care

☐ Transfer to new PCP

☐ Other: _____

I am aware that the record to be disclosed pursuant to this Authorization may contain the following subject matter and I am authorizing the release of such highly sensitive information:

- **Alcohol/Drug use, abuse and/or treatment**
- **Treatment for mental illness and/or social services communications**
- **History of venereal or other communicable disease(s)**
- **Treatment or testing for HIV/AIDS**

I am requesting that the following information be excluded from this release:

_____

This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Patient or Legal Representative Name (print): _____

Patient or Legal Representative Signature: _____ **Date:** _____

Legal Representative Relationship to Patient: _____ **Phone Number:** _____