South Royalton Health Center

79 South Windsor Street
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South Royalton, VT 05068
(802) 763-7575
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Consent For Release of Information

_____I hereby authorize____
to release information from my health record to **South Royalton Health Center, PO Box 119, South Royalton, VT 05068,** with no limitations placed on history of illness or diagnostic and therapeutic information, including any treatment for alcohol or drug abuse, psychiatric impairments or HIV test results/findings.

_____I hereby authorize **South Royalton Health Center** to release information from my health

record to ____
with no limitations placed on history of illness or diagnostic and therapeutic information, including any treatment for alcohol or drug abuse, psychiatric impairments or HIV test results/findings.

Patient Name____**DOB**__________________

Address____

Information covering the period(s) of hospitalization from

Date of Admission________________________ to Date of Discharge_______________________

OR

Information covering outpatient services from

Start date______________________________to_______________________________________

Specific Information to be Released

_____Discharge Summary   _____History
_____Operative Report   _____Physical Exam
_____Other____

Reason for Release____

I understand that this consent can be revoked at any time. This authorization will be valid for one year unless otherwise specified.

Signature of Patient____Date_________________

Relationship and/or authority if signed by person other than patient________________________

Signature of Witness____Date_________________

Note: Signature and Date must be later than the date of the information to be released. Signature of patient is to obtained unless patient is a minor or adjudged incompetent.