Avalon
NATURAL MEDICINE

**Authorization for Release of Protected Health Information**

**Patient Name** (please print)**:**_____ **Date of Birth:**_____

**I authorize the disclosure and use of my health information as described below:**

**Released To:**☐ **Released From:**☐ **Released To:**☐ **Released From:**☐

Dr. Michelle Haff / Dr. Jennifer Williamson _____
Avalon Natural Medicine _____
299 College Street _____
Burlington, VT 05401 _____
(P) 802-578-3449 (F) 877-816-1002 _____

**For the purpose of:** ☐**Adjunctive/Concurrent Care** ☐**Transfer of Care** ☐**Other**

**I specifically authorize the release of the following information:**

Complete Chart Record (does not include billing information or radiographic images)

☐Chart Notes ☐ All ☐ Specify:_____
☐Labs/Reports ☐All ☐ Specify:_____
☐X-Rays/Radiographic Images (specify):_____
☐Other:_____

**Unless specifically excluded**, this authorization includes the release of specifically protected information: referral, diagnosis and treatment information related to substance abuse, mental health/psychotherapy, and HIV/AIDS.

**Check the accompanying box(es) below to EXCLUDE the information from authorization:**

☐**Substance abuse** ☐**Mental health/psychotherapy** ☐**HIV/AIDS**

**I understand the conditions of this authorization:**

1. Unless cancelled by me, this authorization is valid for 12 months from the date of signing or until the date specified herein_____.
2. I may cancel this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
3. If the person/organization receiving health information is not a health plan or healthcare provider, the released information may no longer be protected by state and federal privacy regulations
4. Not agreeing to or cancelling this authorization may result in improper diagnosis or treatment, or denial of health benefits or other insurance coverage, but is not a condition for receiving medical treatment.
5. I understand that the term, *Complete Chart Record*, regarding release of protected health information means that only records generated by the named facility will be released.
6. I am entitled to a copy of this authorization form at the time of signing.

Date:_____

Patient/Representative Signature: _____

If signed by a representative, indicate relationship:_____