Water and Grace Healing Space
PO Box #7, Hyde Park, VT 05655
P: (802) 610-2181
F: (844) 689-2490

Authorization for Release of Medical Records

Patient Information:

Name: _____ Date of Birth: _____

Phone: _____ Address: _____

I hereby authorize:

Name/Facility: _____Address: _____

Phone: _____ Fax: _____

To release my medical records to:

Receiving Provider/Facility: _____ Address: _____

Phone: _____ Fax: _____

Information to be Released (check all that apply):

- ☐ Complete Medical Record ☐ Progress Notes ☐ Lab Reports
- ☐ Imaging Reports
- ☐ Immunization Records
- ☐ Imaging Reports
- ☐ Other (specify): _____

Purpose of Disclosure:

- ☐ Continuation of Care
- ☐ Personal Use
- ☐ Insurance
- ☐ Legal
- ☐ Other (specify): _____

Authorization Expiration:

This authorization will expire one year from the date of signature unless otherwise specified.
Expiration Date: _____

Patient Rights:

I understand that I may revoke this authorization at any time by submitting a written request to the releasing provider. Revocation will not apply to records already released in reliance on this authorization. I understand that once my records are released, they may be subject to redisclosure by the recipient and may no longer be protected under HIPAA. I understand that I am not required to sign this authorization and that treatment will not be conditioned on my signing it.

Signature: Patient or Legal Representative: _____ Date: _____

Relationship (if not patient): _____

Witness (if required): _____ Date: _____