ASSOCIATES IN PRIMARY CARE, LLC
225 South Main Street, Rutland, VT 05701
Phone: 802.770.1850 Fax: 802.770.1851

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION
for use or disclosure of protected health information

Please send by: ○ FAX to _____ ○ RRMC Courier
○ US Mail (if more than 10 pages)

Patients Name: _____ DOB: _____
Address of Patient: _____
_____
Best contact telephone number for patient: _____
Disclosed Information:
○ Reports: Lab ○ ER reports ○ Consultations
○ Mental Health records
○ Radiology/Xrays ○ Operative reports ○ Drug/Alcohol Treatment
○ EKG/Cardiac Testing ○ Medication Hx ○ Hospital H&P ○ Discharge Summary ○ Other: _____

Information to be provided TO/FROM (please circle):
Name of person/provider/institution: _____
Address: _____
_____
Telephone #: _____ Fax #: _____

Purpose/Use of requested information:
○ Transfer of Care
○ Collaboration with other providers
○ Personal use by patient
○ OTHER (please specify):
_____

Authorization:
I hereby authorize Associates in Primary Care, LLC to disclose the health information as described above. I understand that I may revoke this authorization at any time, and must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that for printed records, I may be asked to pay a reasonable fee. My refusal to sign this authorization will not affect my ability to receive treatment.

Signature of Patient or Patient Representative:

_____Date: _____

Signature of Witness:

_____Date: _____

Kimberly Eugair, MSN, FNP-C Family NP

Alma Winther, MSN, AGPCNP-BC Adult-Gerontology PCP NP