



Evergreen Family Health
28 Park Ave, Williston, VT 05495
ph(802)878-1008 Fax(802)872-2679

Authorization to Release Medical Information

I authorize Evergreen Family Health To **send** medical information to:

I understand that my records may contain sensitive medical and personal information.

I consent to the release of the following medical information if it is included in the medical records:

(You must initial all four boxes or come in and personally review your medical records to tell us which information you wish to **withhold**.)

(1) Behavior health, mental health, relationship issues, sexual health issues, abuse, neglect

(2) HIV testing, counseling, and risk discussions

(3) Alcohol and substance abuse information

(4) I waive my right to review my medical records before information sent

I have personally reviewed my medical records on _____.

I wish to withhold the following information:

Name: (Please Print) _____ DOB: _____

*Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name: _____

***Please note : Unless otherwise specified, this release expires one year from signature date above.**