VERMONT

Department of Health
Board of Medical Practice
280 State Drive
Waterbury, VT 05671-8320
(802) 657-4220

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I AUTHORIZE THE VERMONT DEPARTMENT OF HEALTH, BOARD OF MEDICAL PRACTICE to disclose to (1) _____ *(the healthcare professional identified in the complaint)*, and (2) the Office of the Attorney General, the following Protected Health Information related to _____ *(name of patient)*, for the purpose of investigation and/or disciplinary action:

1. The Complaint Form, submitted on _____, including any attached records;
2. Medical records related to the complaint obtained by the Board of Medical Practice.

Only in regard to this specific authorization for disclosure to (1) the above-named healthcare professional and (2) the Office of the Attorney General, and for no other purpose, I hereby expressly WAIVE confidentiality and/or any privileges or immunities accorded this information by State or Federal law, including materials covered by 42 CFR, Part 2, and I hold the Vermont Department of Health, Board of Medical Practice harmless from disclosure of same.

This authorization is subject to revocation at any time except to the extent that you have already taken action in reliance on it. This authorization can be revoked by submitting a request, in writing, to the Vermont Department of Health, Board of Medical Practice, at the address indicated above. If not previously revoked, this authorization will terminate upon final action, including a judicial determination of any action taken by the Board of Medical Practice that is related to this information or, if no such action is taken, will terminate five (5) years from the date hereof.

I understand that the Vermont Department of Health, Board of Medical Practice may not be able to investigate the complaint if this authorization is not given. I also understand that information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by law.

A photocopy of this authorization shall have the same force and effect as the original.

NAME (printed) _____ Date of Birth _____

Address _____ Relationship to Patient (if not self) _____

Address _____

City/State/Zip _____

Signature _____ Date _____