

Medical Records Release Form

By signing this form, I authorize Blue Spruce Health to RELEASE confidential health information about me, by sending a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed below. Patient name: Date of Birth: The information to be released is as follows: Initial next to each selection to also include: _____ Genetic Testing Information Mental Health Information HIV/AIDS Information _____ Substance Abuse Diagnosis/Treatment Send my protected health information **TO** the following physician/person/facility/entity: Name: _____ Address: City/State/Zip: _____ Phone: ______ Fax: _____ Signature of Patient or Personal Representative Date

Description of Personal Representative

Blue Spruce Health

Printed name

Fax: 802-221-4549 Phone: 802-500-6923

Email: info@bluespruce.care