

ACCT# _____ MR # _____ REQUEST DATE: _____ EXP DATE: _____

Protected Health Information Release Authorization

Full Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

This will authorize North Country Hospital & Medical Practices

Address: 189 Prouty Drive, Newport, VT 05855 Phone #: 802-334-3266

to disclose my protected health information to _____

PURPOSE:

Transfer of Care / Coordination of Care / Sharing Care for Seasonal / Other _____

Dates of care include: _____ to _____

Type of Information Requested	
<p>HOSPITAL RECORD</p> <p>Hospital Abstract (includes any available documents below OR check only those documents needed)</p> <p><input type="checkbox"/> Discharge Summary <input type="checkbox"/> Lab Results <input type="checkbox"/> Path Report</p> <p><input type="checkbox"/> History & Physical <input type="checkbox"/> EKG Report <input type="checkbox"/> Consultation</p> <p><input type="checkbox"/> Operative Report <input type="checkbox"/> ED Report</p> <p><input type="checkbox"/> Radiology Report <input type="checkbox"/> Other: <input type="checkbox"/> All</p>	<p>PHYSICIAN OFFICE RECORD</p> <p>Clinical Abstract (includes any available documents below OR check only those documents needed)</p> <p><input type="checkbox"/> Office Notes <input type="checkbox"/> Problem Lists</p> <p><input type="checkbox"/> Medication Lists <input type="checkbox"/> Immunizations</p> <p><input type="checkbox"/> Lab/Radiology Reports</p> <p><input type="checkbox"/> Other: <input type="checkbox"/> All</p>

Please be advised that information, if any, regarding the following areas of treatment could be included in the records: behavioral/mental health services, HIV/AIDS related illness, drug / alcohol abuse treatment, and genetic testing. **FOR 12-17 YRS OLD** for Reproductive Health & STD Test/Treatment. To withhold any of such records, please specify which:

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that North Country Hospital shall not refuse to treat me if I refuse to sign this authorization.
- I understand that I have the right to revoke this authorization at any time, although the revocation will not be effective to previously released protected health information pursuant to a valid authorization. If I revoke this authorization, I must do so in writing addressed to: North Country Hospital, Health Information Management, 189 Prouty Drive, Newport, VT 05855.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and may no longer be protected by federal and state privacy regulations.
- I understand that I may be charged a fee for copies in accordance with state and federal law.

X _____
Signature of Patient or Legal Representative

X _____
Date

X _____
Printed Name of Patient or Legal Representative

Relationship to Patient (if signed by Legal Representative)
(Attach copy of documentation of Authority to Act for Patient)

EXPIRATION DATE: This authorization will expire on (no later than one year from today) _____ (If no date is stated, this authorization expires one year from the date it was signed.)

Page Count: _____ Date Released: _____ Method of Release: _____

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