

Northeastern Vermont Regional Hospital  
1315 Hospital Drive  
St Johnsbury VT 05819

MRN: \_\_\_\_\_  
Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

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Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # \_\_\_\_\_

**PERMISSION TO SHARE:** I give my permission to share my protected health information. Enter where you would like information sent to, or information you would like sent from.

**Information to:** Pick up Send out **Date of Request:** \_\_\_\_\_ **Date Needed:** \_\_\_\_\_

**Receive information from:**  
 **Send information to:**  
St. Johnsbury Pediatrics  
97 Sherman Drive  
St. Johnsbury, VT 05819  
Phone: 802-748-5131 / Fax: 802-748-4237

**Receive information from:**  
 **Send information to:**  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

**Purpose for Release:**

- Current Treatment    Personal Records    Insurance    Worker's Compensation  
 Attorney/Legal Claim    Provider Transfer    Disability    Other (please specify): \_\_\_\_\_

**INFORMATION TO BE RELEASED** (please check all that apply and specify dates):

- Hospital Abstract (e.g. History & Physical, Consult Notes, Progress Notes, All Clinical Charts, etc. )  
 Discharge Summary  
 Operative Report, Test Results, Discharge Summary)       Clinic Visit Notes  
 Lab Reports       Radiology Reports  
 Operative Reports       Radiology Images  
 Pathology Reports       ED Report  
 Immunizations       Medication List  
 Physical, Occupational, Speech Therapy Notes  
 Other (please specify): \_\_\_\_\_

**Dates of Care to be Released:** \_\_\_\_\_ to \_\_\_\_\_

Information Released/Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only.**

Identification verified by: \_\_\_\_\_ Date: \_\_\_\_\_

NORTHEASTERN VERMONT REGIONAL HOSPITAL  
1315 Hospital Drive  
St Johnsbury VT 05819

MRN: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Authorization to Disclose Protected Health Information

Page 1 of 2

1. I AUTHORIZE NORTHEASTERN VERMONT REGIONAL HOSPITAL AND ITS AGENTS TO RELEASE THE REQUESTED PROTECTED HEALTH INFORMATION TO OR RECEIVE PROTECTED HEALTH INFORMATION FROM THE PARTIES LISTED ON PAGE 2 OF THIS DOCUMENT.
2. By signing this form I am certifying that I am the patient or, a legally authorized representative (Health Care Agent Legal Guardian, Executor, etc.
3. I understand that if the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, my request for information will be submitted for processing.

**I understand that:**

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health services, and treatment of alcohol or drug abuse. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance use disorder records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
- I may be charged a fee for copies in accordance with the state and federal law.
- I have a right to revoke this authorization at any time by submitting a written request to the Department or Office where I originally submitted it. My revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health services at Northeastern Vermont Regional Hospital.

**Expiration of Authorization:**

I understand that this authorization will expire on \_\_\_\_\_ (insert expiration date). If I do not specify an expiration date, this authorization will expire 1 year from the date I signed the authorization.

\_\_\_\_\_  
**Signature of Patient/Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship to Patient**  
(If signed by Legal Representative)

**Please Return to:**  
**St. Johnsbury Pediatrics**  
**97 Sherman Drive**  
**St. Johnsbury, VT 05819**  
**Phone: 802-748-5131 / Fax: 802-748-4237**