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

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)

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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: ☐ Receive information from:

- ☐ Pick up
- ☐ Send out

Name: _____
Address: _____
Telephone Number: _____
Fax Number: _____
Date of Request: _____ Date Needed: _____

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)
☐ Lab Reports
☐ Operative Reports
☐ Pathology Reports
☐ Immunizations
☐ Physical, Occupational, Speech Therapy Notes
☐ Other (please specify): _____
☐ Clinic Visit Notes
☐ Radiology Reports
☐ Radiology Images
☐ ED Report
☐ Medication List

Dates of Care to be Released: _____ to _____
Information Released/Reviewed by: _____ Date: _____

For office use only.

Identification verified by: _____ Date: _____