North Country Hospital
Where caring runs deep.

Health Information Management
Phone: 802-334-3266
Fax: 802-334-4105

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	
HOSPITAL RECORD Hospital Abstract (includes any available documents below OR check only those documents needed) ☐ Discharge Summary ☐ Lab Results ☐ Path Report ☐ History & Physical ☐ EKG Report ☐ Consultation ☐ Operative Report ☐ ED Report ☐ ALL ☐ Radiology Report ☐ Other:	**PHYSICIAN OFFICE RECORD** Clinical Abstract (includes any available documents below OR check only those documents needed) ☐ Office Notes ☐ Problem Lists ☐ Medication Lists ☐ Immunizations ☐ Lab/Radiology Reports ☐ ALL ☐ Other:

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_____   X_____
Signature of Patient or Legal Representative   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:_____

IROI

708-Protected Health Information release authorization 11/28/05, 09/20/11, 10/29/12, 3/28/18