NOTCH

Northern Tier Center For Health

Alburg • Enosburg • Richford • St Albans • Swanton

CONSENT FOR TREATMENT

I hereby give my consent to Richford Health Center, Inc. dba Northern Tier Center for Health (NOTCH) to administer medical/dental treatment, local anesthetics and to perform any diagnostic laboratory studies necessary.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected heath information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize physicians and staff of Richford Health Center, Inc. dba Northern Tier Center for Health (NOTCH) to give verbal information about my (or the patient named below if I am the legal representative) appointments, medical care, test results and billing, with the following persons:

Name	Phone Number	Relationship to Patient
1.____________	____________	____________
2.____________	____________	____________
3.____________	____________	____________
4.____________	____________	____________

Release of information under this authorization is limited to verbal discussions. **This authorization does not permit release of any written health information to the individuals named above. This authorization does not provide the above named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.**

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the health center listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I understand that I may inspect or copy the protected health information described by this authorization. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I also authorize any institution, agency or person involved in my care to release my personal health information to the above indicated health center or dental clinic. This consent for authorization will expire and be renewed on the first service date of each calendar year.

________________________ (Print Patient Name and Date of Birth)

________________________ (Patient Signature and Date)

________________________ (Signature of Representative and Date if Applicable)

________________________ (Authority or Relationship of Representative)

You are entitled to a copy of this consent and a copy of the Notice of Privacy Practices