NOTCH
Northern Tier Center for Health
Federally Qualified Health Center

Protected Health Information Release Authorization

Full Name _____ DOB _____

This will authorize _____ Phone: _____

To use or disclose my protected health information to: Northern Tier Center for Health (NOTCH)

Address: Attn: Richford Dental Clinic, 44 Main Street, Suite 200, Richford, VT 05476

Phone/Fax: P: 802-255-5520 F: 802-255-5529

as described below for the following purpose: ☐ Continuity of Care ☐ Other: _____

Specific Information to be sent:

☐ All Records OR

☐ Diagnostic Imaging Reports
☐ Dental Records
☐ Immunizations
☐ Other: _____

☐ Lab Reports
☐ Consult Notes
☐ Office Notes

Dates of care include: _____

- I understand that this authorization may be revoked in writing at any time, although revocation will not be effective as the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information to be released may include treatment related to: mental health, behavioral health, HIV/AIDS.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Signature of Individual or Representative Date

_____
Authority or Relationship of Representative

EXPIRATION DATE: This authorization will expire on _____

(If no date or event is stated, expiration is one year from the date it was signed.)