NORTHERN TIER CENTER FOR HEALTH

NOTCH

Protected Health Information Release Authorization and Consent

Patient's Full Name: _____ DOB: _____

This will authorize (Organization's Name): _____

Address: _____ Phone/Fax: _____

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

Address: Please Select Clinic

AND:

Name: _____ Phone/Fax: _____

Address: _____

As described below for the following purpose(s): ☐ Continuity of Care ☐ Other: _____

Specific Information to be sent:

☐ All Records OR ☐ Diagnostic Imaging Reports ☐ Lab Reports

☐ Dental Records ☐ Consult Notes ☐ Immunizations

☐ Office Notes ☐ Other: _____

☐ Substance Use Disorder Treatment Records provided prior to 2022 (including Medication Assisted Treatment records)

Other (please specify): _____

Dates of care include: _____

Electronic Documentation Received on CD or DVD: *Please send to Richford Health Center – Care Coordination Department 44 Main Street, Ste. 200, Richford, VT 05476*

By Signing below, I authorize release of records and 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.
- Information to be released may include treatment related to: substance use disorder treatment and diagnosis, mental health, behavioral health, HIV/AIDS.
- 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. *Substance use disorder treatment records prior to 2022 are prohibited from redisclosure.

This authorization will expire on: _____

(If no date or event is stated, expiration is one (1) year from date it was signed)

_____ _____

Signature of Individual or Representative Date

_____

Authority or Relationship of Representative