



# 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: \_\_\_\_\_

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  
Federally Qualified Health Center serving Franklin and Grand Isle Counties  
Protected Health Information Release Authorization