NORTHERN TIER
CENTER FOR HEALTH

Protected Health Information Release Authorization and Consent

Patient Name: ____Date of Birth: ___________________________

Address: ____

Home Phone: _________________________________Cell Phone:____

Information Requested From**:** ____

Address:____

Email:_________________________________Phone: __________________________Fax: _____________________

Information Released To: Northern Tier Center for Health (NOTCH)____

Adress/Phone/Fax: ____

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

☐ All Records OR ☐ Diagnostic Imaging Reports ☐ Lab Reports
☐ Dental Records ☐ Consult Notes ☐ Immunizations
☐ Office Notes ☐ Other:____

Other (please specify):____

Dates of care include:____

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

I understand that if I do not state a date of expiration below, then this consent will expire one year from the last date of service to me at the Northern Tier Health Center (NOTCH). I understand that information released may include medical, psychiatric, mental health and/or drug and alcohol records. I understand that my Medical Records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by state and federal regulations. A photocopy or facsimile of this consent is valid as is the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. You are authorizing the Northern Tier Center for Health (NOTCH) to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here.

This authorization will expire on:____

(If no date or event is stated, this release will expire one (1) year from the last visit the patient had)

____ _______________________________
Patient Signature: Date

____ _______________________________
Guardian or Legal Representative Signature Date

I understand that I may revoke this consent at any time. My decision to revoke this consent will not affect the records that were previously released under this consent. I hereby revoke this consent on: ______________ (date). Do not release any further information under this consent.
Signature: ____________________________________