



Name (first, last, middle initial): _____ Maiden/Other Name: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Mailing Address (if different): _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile: _____ Carrier: _____ Work: _____
Email: _____ DOB: _____ SSN: _____

Sex
RACE (Select all that apply)
ETHNICITY

Primary Language: _____ Do you need interpreter services? [] Yes [] No
Primary Pharmacy: _____ Secondary Pharmacy: _____
Insurance Information: Please complete the following Insurance information and provide a copy of insurance card(s)

Primary Medical [] Same as patient
Ins Company: _____
ID #: _____ Grp #: _____
Policy Holder Name: _____
DOB: _____ SSN: _____

Primary Dental [] Same as patient
Ins Company: _____
ID #: _____ Grp #: _____
Policy Holder Name: _____
DOB: _____ SSN: _____



Person financially responsible, if not the patient – e.g. Parent of a minor child:

Name: _____ Address: _____

Phone: _____ Home/Work: _____ DOB: _____

Emergency Contact: _____

Marital Status		Are you a U.S. Veteran?	Are you an Agricultural Worker?
<input type="checkbox"/> Annulled	<input type="checkbox"/> Divorced	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> No	<input type="checkbox"/> Migratory
<input type="checkbox"/> Married	<input type="checkbox"/> Never Married		<input type="checkbox"/> Seasonal
<input type="checkbox"/> Widowed			
Employment Status		Housing Status	
<input type="checkbox"/> Full Time	<input type="checkbox"/> Self-Employed	Are you Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Part Time	<input type="checkbox"/> Not Employed	If Homeless, are you:	
		<input type="checkbox"/> Doubling up (living with others)	
		<input type="checkbox"/> Staying in a Shelter	
		<input type="checkbox"/> On the Street	
		<input type="checkbox"/> Living in Transitional Housing	
Student Status			
Are you a student?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			

Name of Person Completing This form (if other than patient): _____

Check here if the person completing this form has legal authority to consent for treatment of the registrant (requires supporting documentation if other than parent of a minor)

Income Information: Please check the appropriate box next to family size and corresponding household income range on the table below. As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Family Size	0-100% Federal Poverty Level		101-150% Federal Poverty Level		151%-200% Federal Poverty Level		Over 200% Federal Poverty Level						
	Household Income Range based on Family Size												
1	\$0	to	\$15,960	\$15,961	to	\$23,940	\$23,941	to	\$31,920	\$31,921	& over		
2	\$0	to	\$21,640	\$21,641	to	\$32,460	\$32,461	to	\$43,280	\$43,281	& over		
3	\$0	to	\$27,320	\$27,321	to	\$40,980	\$40,981	to	\$54,640	\$54,641	& over		
4	\$0	to	\$33,000	\$33,001	to	\$49,500	\$49,501	to	\$66,000	\$66,001	& over		
5	\$0	to	\$38,680	\$38,681	to	\$58,020	\$58,021	to	\$77,360	\$77,361	& over		
6	\$0	to	\$44,360	\$44,361	to	\$66,540	\$66,541	to	\$88,720	\$88,721	& over		

*Add \$5,500 per additional over 6

Effective 1/13/2026



Medical History Questionnaire

Name: _____ DOB: _____ Today's Date: _____

Height: _____ Weight: _____ Previous Primary Care Provider: _____

Other Care Team Provider (e.g. specialist, out of state providers etc.): _____

	Yes	No	Don't Know
Advanced Directive:			
Do you have an Advanced Directive? <i>(if yes, please provide a copy)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you like the Health Center to assist you in developing your Advanced Directive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions as best you can, your answers are confidential.

Have there been any major changes to your health within the past year? Yes No Don't Know

If yes, please explain: _____

Do you have any artificial joints, heart valves, implants, or prosthesis? Yes No Don't Know

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition? Yes No Don't Know

If yes, please explain: _____

Females Only:

Are you currently pregnant? Yes No Don't Know

If Yes, Due Date: _____

Are you currently breast feeding? Yes No

Health History: *Do you currently have, or have you had any of the following? (Check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Addiction | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Anxiety/Panic Disorder/ PTSD | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Asthma or Shortness of Breath | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Back or Neck Problems | <input type="checkbox"/> Gynecological Problems |
| <input type="checkbox"/> Blood Disease or Anemia | <input type="checkbox"/> Hearing Loss/ Ringing in Ears |
| <input type="checkbox"/> Bowel Disease or Ulcers | <input type="checkbox"/> Heart Disease or Chest Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure Prostate |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Trouble |
| <input type="checkbox"/> Headaches or Migraines | <input type="checkbox"/> Liver Disease or Hepatitis |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer or Tumor Location: _____ | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Panic Disorder |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Fractures, Bone/Joint | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Deformities Gout | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eye Trouble, Injury, or Blindness | <input type="checkbox"/> Other: _____ |



Medical History Questionnaire

Name: _____ DOB: _____ Today's Date: _____

Health Screening: Please note the date of your last screening/occurrence for the following:

- Colonoscopy Date: _____ PSA _____
Mammogram Date: _____ Pap Smear _____

Last Menstrual Period Date: _____

Surgical History:

- Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____

Family History: Has anyone in your immediate history experienced the following?

Table with 5 columns: Condition, Father, Mother, Sibling, Child. Rows include Cancer or Tumor, Diabetes, High Blood Pressure, Heart Disease / Heart Attack, Mental Health, Substance Abuse, and Other. Includes a checkbox for 'I am adopted and do not know my family history'.

- Father Deceased Date of Death: _____ Cause of Death: _____
Mother Deceased Date of Death: _____ Cause of Death: _____

Social History (Check all that apply)

- Alcohol Use Amount: _____
Drug Use
Smoker
Former Smoker Estimated Quit Date: _____
Chewing Tobacco
Abuse/Neglect
Employed Occupation: _____
Occupational Injury Details: _____
Retired
Living with Spouse
Living Alone



Medical History Questionnaire

Name: _____ DOB: _____ Today's Date: _____

Allergies:

Medication Allergies / Reaction _____

Food, Environmental, Animal Allergies / Reaction _____

Current Medications:

Medication	Dosage	Frequency	Reason for Medication?

Immunizations:

Date of Last Tetanus Shot: _____ If unknown, was it in the last 10 years? Yes No Don't Know

Have you ever received the pneumovax pneumonia vaccine? Yes No Don't Know

If yes, date vaccine received: _____

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to the Northern Tier Center for Health.

We set aside time just for you. If you're running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment.

Signature of Patient or Guardian

Date



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)

Address/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: _____



Consent for Treatment, Payment, and Healthcare Operations

Patient Name: _____ **Date of Birth:** _____
Please Print Please Print

I. Consent for Treatment:

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian of and have the legal right to consent to treatment) to the Northern Tier Centers for Health (NOTCH). Treatment may include health screening, diagnosis, medical treatment, dental treatment, mental health, psychiatry services, and drug and alcohol screening, assessment, diagnosis, and treatment.

II. Consent to Release Health Information

I consent to the use within NOTCH and the disclosure to persons or organizations outside of NOTCH of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, Care Quality Interoperative (HIE), Surescripts/Pharmacy, drug and alcohol, mental health, psychiatry and other treatment and health records (“health information”) by NOTCH for the following purposes:

A. Use of health information by or for NOTCH for treatment, payment, and health care operations.

- Providing treatment by NOTCH staff
- Conducting health care operations, including financial or quality assurance audits and / or training.
- Prescription ordering/refilling
- Billing your insurance company directly
- Processing payment for healthcare services, including the disclosure of health records to insurance companies, workers' compensation or liability carriers, or other agencies responsible for payment. This may also include updating insurance information on file with NOTCH.

B. Disclosure of health information to people or organizations outside of NOTCH for treatment purposes:

- NOTCH is authorized to provide all past and present health information including 42 CFR. Part 2 document to other health care providers or agencies who participate in your care. This includes past medical records from outside organizations, prescriptions, drug and alcohol screening, diagnosis, and treatment.
- An individual release of information must be submitted for each transfer of care, family, friends, or other people that you wish to have access to your Medical Record information.

III. Assignment of Benefits

I authorize NOTCH to bill and receive payment directly from Medicare / Medicaid or any other insurance carrier for services provided to me.



I hereby assign to all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to be me by NOTCH.

I understand I am responsible for any unpaid balances incurred due to my care at NOTCH.

I understand that, to the best of my knowledge, the demographic information I provided is true and correct.

IV. Termination and restrictions of this consent:

- A. I understand that I may revoke this consent at any time by providing written notice to NOTCH. Revocation will not affect any actions taken by NOTCH in reliance on this consent prior to the date of revocation. Unless otherwise revoked in writing, this consent will expire three (3) years after the date of my last service with NOTCH.
- B. I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that NOTCH may or may not agree to the request. I also understand that except for those restrictions on use or disclosure of health information to which NOTCH agrees, NOTCH will not be able to provide services to me (or the named patient without this signed consent.
- C. I have read this Consent for Treatment & Consent to the Release of Health Information; I understand and knowingly consent to its content.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand NOTCH will use my protected health information in accordance with privacy law.

Patient Signature: _____ Date: _____

Parental Signature: _____ Date: _____

Guardian Signature/ POA: _____ Date: _____

If you are a legal guardian/power of attorney of a patient, this document is not valid until legal paperwork is provided.



Authorization to Treat a Minor Without a Parent/Guardian Present

Northern Tier Centers for Health (NOTCH) requires authorization from the parent or legal guardian of a minor before providing non-emergency medical treatment for injuries or illnesses. This form provides NOTCH and its healthcare providers with your consent to assess and treat your minor child when you are not present.

I, _____, hereby authorize NOTCH and its providers to conduct medical/dental evaluations, diagnostic testing, and treatment for the minor child named below. I affirm that I am the parent and/or legal guardian of this child.

I understand and acknowledge that in my absence, medical and dental care may be rendered to my child without my direct supervision. I have been informed of the nature of the possible treatments and/or procedures listed below and understand the associated risks. I further understand that I am solely responsible for any charges, fees, or expenses related to the services provided.

This authorization is valid from the date of signature until the minor reaches 18 years of age unless revoked in writing prior to that time.

Minor Child's Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Any care beyond the outlined categories will require a parent or guardian to be present. Extractions and other advanced procedures will only be performed after a direct conversation with NOTCH. Additional consent forms must be signed for advanced treatments.

(Please check all that apply)

- All treatments
- Physical examination and/or first aid
- Medical and nursing management of acute or chronic illness
- Immunizations (including those required for school)
- Sports physicals
- Laboratory testing
- Dental screenings, cleanings, fillings, and x-rays as needed
- Treatment for dental pain, infection, or bleeding
- Administration of medications required for visit

Patient Signature (if applicable): _____ Date: _____

Parent Signature: _____ Date: _____

Guardian/POA Signature: _____ Date: _____

If signing as a legal guardian or power of attorney, legal documentation must be provided for this form to be valid.



Vermont State Law

State of Vermont Guidelines: Informed Consent Individuals under the 18 years of age are minors under Vermont law [1 V.S.A. § 173]. Therefore, a minor's parent or guardian must provide informed consent for the minor to undergo medical treatment or a procedure with the following **exceptions:**

Minors of any age

- An individual of any age (including minors) may be treated without informed consent in an emergency [12 V.S.A. § 1909(b)].
- Minors of any age may give informed consent to:
 - Medical treatment associated with rape, incest, or sexual abuse. Health care providers are required to report such incidents to the Department for Children and Families within 24 hours [33 V.S.A. § 4911 et seq.].
 - Outpatient mental health treatment, including psychotherapy and counseling services, but not prescription drugs [18 V.S.A. § 8350].
 - Reproductive care, including contraceptive devices, termination of pregnancy, prenatal, delivery, and other pregnancy care [18 V.S.A. § 9493].

Minors 16 years of age and older

- Minors who are 16 years of age and older may consent to donate blood to a voluntary blood donation program where no compensation is received [18 V.S.A. § 9].

Minors 14 years of age and older

- Minors who are 14 years of age and older may apply for voluntary admission to a designated hospital for mental health related evaluation and treatment. Informed consent must be in writing and must include a representation that the person (a) understands that treatment will involve inpatient status, (b) desires to be admitted to the hospital, and (c) consents to voluntary admission without coercion or duress [18 V.S.A. § 7503].

Minors 14 years of age and younger

- Minors under 14 years of age may admit themselves to a hospital for mental health-related treatment by providing their own written informed consent and a written application from a parent or guardian [18 V.S.A. § 7503].

Minors 12 years of age and older

- Minors who are 12 years of age and older may give informed consent to testing and treatment for sexually transmitted diseases including HIV and AIDS, substance use, or substance use disorder. But, if a minor requires immediate hospitalization for treatment of any of these conditions, the parents shall be notified of the hospitalization [18 V.S.A. § 4226]

Confidentiality & Insurance Communications:

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, unless modified by State or other law, a minor who has the authority to consent to a health care service has the same authority to restrict the use and disclosure of the minor's protected health information (PHI) related to that service as if the minor were an adult [45 CFR § 164.502(g)(3)]

The HIPAA Privacy Rule requires that covered entities (including health insurance plans) permit an individual to request that the covered entity restrict uses or disclosures of PHI about the individual to carry out treatment, payment, or health care operations [45 CFR § 164.522(a)(1)(i)(A)]. A health insurance plan may, but is not required to, agree to a requested restriction, except that a health insurance plan must accommodate reasonable requests by individuals to receive communications of PHI from the health insurance plan by alternative means or at alternative locations if the individual clearly states that the disclosure of all or part of that information could endanger the individual [45 CFR § 164.522(a)(1)(ii); 45 CFR § 164.522(b)(1)(ii)]

The above information outlines the basic tenets of a minor's authority to restrict the use or disclosure of the minor's PHI related to a health care service (where the minor has the authority to consent to the health care service without a parent or guardian's consent) and why the minor may therefore request changes to how health insurance plan communications about that service are received.

[S.37~Amerin Aborjaily~Informed Consent Laws for Minors~4-12-2023.pdf](#)



NOTCH Patient Portal – Authorized Representative

Manage your child's health online

The **NOTCH Patient Portal** provides real-time access to your child's health information including medications, labs, progress notes, and upcoming appointments - whenever you need it. You can also request an appointment, medication refills, and message your care team. Signing up is as easy as 1, 2,3...

The image shows two screenshots of the Northern Tier Center for Health Portal. The left screenshot is the login page, featuring a search bar, a 'Sign in' button, and links for 'Forgot password?' and 'Forgot login name?'. Below these are links for 'New to the patient portal?' and an 'Activate account' button. The right screenshot shows the 'Northern Tier Center for Health Portal' interface with a navigation menu on the left (Messages, Create Message, Inbox, Saved Messages, Sent Messages, Appointments, Medications, Allergies, History, Chart, Account Info) and a message list on the right. The message list includes buttons for 'Create Message', 'Refresh', 'Move to Saved', and 'Delete Message'. Below these buttons is a table of messages:

<input type="checkbox"/>	Date	Time	Subject
<input type="checkbox"/>	02/27/20	9:17 am	Imm: Tetanus, Diphtheria Toxoids
<input type="checkbox"/>	02/27/20	9:15 am	CCD
<input type="checkbox"/>	02/27/20	9:12 am	Thyroid Education
<input type="checkbox"/>	12/06/19	10:23 am	Hgba1c Panel

Step 1: Call the NOTCH Location where your child receives medical care and ask to be added as an authorized representative to your child's patient portal account or ask front desk staff when you check in for your next appointment. Please note, if your child is 12 to 17, he or she will be asked to sign a consent granting you access to his or her patient portal account.

Step 2: Go to our website, www.notchvt.org, and click on the link for patient portal. Click on "Activate Account" to start. Complete the form entirely, making sure to enter your last name, first name, and DOB exactly how they appear on your portal use by authorized representative activation letter. If you need help, click on the "View a video Tutorial" link at the top of the page.

This screenshot shows the 'Northern Tier Center for Health Portal' logo at the top. Below the logo, there is a link that says 'New to the patient portal?' and a prominent blue button labeled 'Activate account'.

Step 3: That's it! Navigate through your health information using the links on the left-hand side of the page

- Use the "Messages" link to send or view messages
- Use the "Documents" link to view your progress notes
- Use the "Chart" link to view a chart summary including lab results

The NOTCH patient portal provides secure access to your health information online whenever you need it – Activate your account today!



NORTHERN TIER CENTER FOR HEALTH

NOTCH Network Pharmacies

Located in

Fairfax	Richford	St. Albans	Swanton
(802)849-2101	(802)255-5530	(802)527-6700	(802)868-3338

WELCOME TO ALL!

Hours by location:

Monday – Friday 8:30-5:30 @ Fairfax, St. Albans & Swanton

Monday 9:00-7:00, Tuesday – Friday 9:00-5:30 @ Richford

Saturday 9:00 – 12:00 – All Pharmacies

Drive-Thru available (Swanton)

Free Mailing Available

Get your medications filled on the same day each month

Pick up a Free Medication Box!

Check out our website → www.notchvt.org



WHERE SHOULD YOU GO?



Primary Care

- Wellness or preventative visits
- Chronic condition management (diabetes, heart failure, COPD, asthma, hyper tension)
- Vaccinations
- Cold and flu symptoms
- Migraines
- Allergy symptoms
- Skin issues
- Minor fevers
- Earaches/infections
- Pink eye
- Sprains and strains
- Cuts that require stitches
- Minor fractures or sprains
- Minor injuries
- Urinary tract infections
- Severe back pain
- Vomiting and diarrhea
- Minor reactions to medications
- Animal bites
- Minor illnesses
- Insect bites/tick bites

Emergency Department

- Chest pain
- Seizures
- Uncontrolled bleeding
- Poison ingestion
- Sudden loss of consciousness or inability to move
- Complex fractures
- Coughing or vomiting blood
- Stroke symptoms
- Difficulty breathing
- Severe abdominal pain
- Head trauma
- Severe asthma attack
- Mental health crisis



NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

Call your primary care provider first, we will guide you! We have a provider on call 24/7 including after hours and holidays!

Vermont health information exchange



What is this?

So what is the Vermont Health Information Exchange?

The Vermont Health Information Exchange keeps your health records in one secure place. When you see a doctor or healthcare provider who participates, an electronic record may be sent to the Health Information Exchange. This record is ready for the next doctor you see so they know your health history. This doctor adds to your record so it's ready for the next doctor, and so on.

It puts your providers on the same page.



What are my options?

Now that you know more about the Vermont Health Information Exchange, let's talk about your options.

Participate

If you want the benefit of all your providers having your medical record you have nothing to do. If your providers participate, your records will be shared on the Health Information Exchange.

Get more information before you decide

Your doctor or healthcare provider can answer questions about the Health Information Exchange. Or you can call the Health Information Exchange Hotline at **1-888-980-1243**.

Don't participate

You can choose to not have your records shared with providers. This is called opting out. If you opt out, your record will be stored in the Health Information Exchange. But your providers will not be able to see it, except in emergencies.

To opt out, visit **VTHealthInfo.com** to complete or download the opt out form or call the Health Information Exchange Hotline at **1-888-980-1243**.

If you have questions and want to talk to a resource that is independent of the Vermont Health Information Exchange, call the Health Care Advocate Helpline at 1-800-917-7787.



VTHealthInfo.com

For questions, call the Health Information Exchange Hotline at 1-888-980-1243.

Vermont health information exchange



What's in my record?

Patient records may include:

- Patient demographics
(like name, age, date of birth, address)
- Illnesses
- Injuries
- Conditions
- Allergies
- Medications
- Laboratory test results
- Radiology reports
- Patient care summaries
- Doctor notes
- Limited mental health information*
- Limited substance use disorder
information* (also called addiction)

** Records about mental health and substance use disorder treatment received at some primary care practices, emergency departments, and hospitals may be included. These records may include diagnoses and prescribed medications. At this time, private psychiatrists, mental health counselors and substance use disorder treatment centers do not contribute to the Vermont Health Information Exchange.*

For more, visit VTHealthInfo.com/FAQS

The Vermont Health Information Exchange is operated by Vermont Information Technology Leaders (VITL) and is funded by the State of Vermont as a service to all Vermonters. For more on VITL, visit VITL.net



What's that mean for me?

Having your doctors and healthcare providers on the same page means better care for you.

When providers use the Health Information Exchange, they have access to a shared record. This means you won't have to answer the same questions everywhere. Or remember when things happened. Or know exactly what kind of medication you've taken. And if you ever can't give your information, like in an emergency, the doctor can still get important information to help you.



VTHealthInfo.com

For questions, call the Health Information Exchange Hotline at 1-888-980-1243.