NORTHERN TIER CENTER FOR HEALTH

NOTCH

Patient Registration Form

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: _____

Legal Sex	Current Gender	Sexual Orientation	Gender Identity
☐ Male ☐ Female	☐ Male ☐ Female	☐ Straight or Heterosexual ☐ Bisexual ☐ Lesbian, Gay, or Homosexual ☐ Don't Know ☐ Something Else	☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female) ☐ Other
Preferred Pronoun			
☐ He/him ☐ She/her ☐ They/them ☐ Other:			

RACE (Select all that apply)					
ASIAN	NATIVE HAWAIIAN OR PACIFIC ISLANDER	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR ALASKA NATIVE	WHITE	CHOOSE NOT TO DISCLOSE
☐ Chinese ☐ Vietnamese ☐ Asian India ☐ Korean ☐ Filipino ☐ Japanese ☐ Other Asian	☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan	☐ Black or African American	☐ American Indian or Alaska Native	☐ White	☐ Choose not to Disclose

ETHNICITY		
HISPANIC, LATINO/A, OR SPANISH ORIGIN	NOT HISPANIC, LATINO/A OR SPANISH ORIGIN	CHOOSE NOT TO DISCLOSE
☐ Mexican ☐ American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Hispanic, Latino/A, or Spanish Origin ☐ Another Hispanic, Latino/A, and Spanish Origin	☐ Not Hispanic, Latino/a or Spanish origin	☐ Choose not to disclose

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: _____

NORTHERN TIER CENTER FOR HEALTH

NOTCH

Patient Registration Form

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?
☐ Annulled ☐ Domestic Partner ☐ Married ☐ Widowed	☐ Divorced ☐ Legally Separated ☐ Never Married	☐ Yes ☐ No	☐ No ☐ Migrant ☐ Seasonal

Employment Status		Housing Status
☐ Full Time ☐ Part Time	☐ Self-Employed ☐ Not Employed	Are you Homeless? ☐ Yes ☐ No If Homeless, are you: ☐ Doubling up (living with others) ☐ Staying in a Shelter ☐ On the Street ☐ Living in Transitional Housing
Student Status		
Are you a student? ☐ Yes ☐ 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.*

	0-100% Federal Poverty Level				101-150% Federal Poverty Level				151%-200% Federal Poverty Level				Over 200% Federal Poverty Level	
Family Size	**Household Income Range based on Family Size**													
1	$0	to	$15,650		$15,651	to	$23,475		$23,476	to	$31,300		$31,301	& over
2	$0	to	$21,150		$21,151	to	$31,725		$31,726	to	$42,300		$42,301	& over
3	$0	to	$26,650		$26,651	to	$39,975		$39,976	to	$53,300		$53,301	& over
4	$0	to	$31,320		$31,321	to	$48,225		$48,226	to	$64,300		$64,301	& over
5	$0	to	$36,700		$36,701	to	$56,475		$56,476	to	$75,300		$75,301	& over
6	$0	to	$42,080		$42,081	to	$64,725		$64,726	to	$86,300		$86,301	& over

**Add $5,500 per each additional over 6*

NORTHERN TIER CENTER FOR HEALTH
NOTCH

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.):_____

Advanced Directive:	Yes	No	Don't Know
Do you have an Advanced Directive? *(if yes, please provide a copy)*	☐	☐	☐
Would you like the Health Center to assist you in developing your Advanced Directive?	☐	☐	☐

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?	☐	☐	☐
If yes, please explain: _____			
Do you have any artificial joints, heart valves, implants, or prosthesis?	☐	☐	☐
Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?	☐	☐	☐
If yes, please explain: _____			

Females Only:

Are you currently pregnant?	☐	☐	☐
If Yes, Due Date: _____			
Are you currently breast feeding?	☐	☐	

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

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

NORTHERN TIER CENTER FOR HEALTH
NOTCH

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?*

	Father	Mother	Sibling	Child
Cancer or Tumor	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Heart Disease / Heart Attack	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

☐ **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

NORTHERN TIER CENTER FOR HEALTH

NOTCH

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:

	Yes	No	Don't Know
Date of Last Tetanus Shot: _____ If unknown, was it in the last 10 years?	☐	☐	☐
Have you ever received the pneumovax pneumonia vaccine?	☐	☐	☐

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

NORTHERN TIER CENTER FOR HEALTH

NOTCH

Protected Health Information Release Authorization and Consent

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____ Cell phone: _____

Information Requested From: _____ Email: _____

Address: _____ Phone/Fax: _____

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

Address: Please Select a Clinic 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: _____

MEDENT Customers: *Please send by Direct N2N Message - Practice@notch.medentdirect.com*
Electronic Documentation Received on CD or DVD: *Please send to Richford Health Center – Care Coordination Department 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: _____

NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

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.

NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

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)]

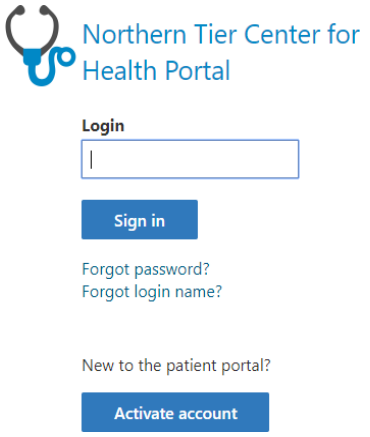
The above information outlines the basic tenets of a minor's authority to restrict the use or disclosure of the minor's PHI related to a health care service (where the minor has the authority to consent to the health care service without a parent or guardian's consent) and why the minor may therefore 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

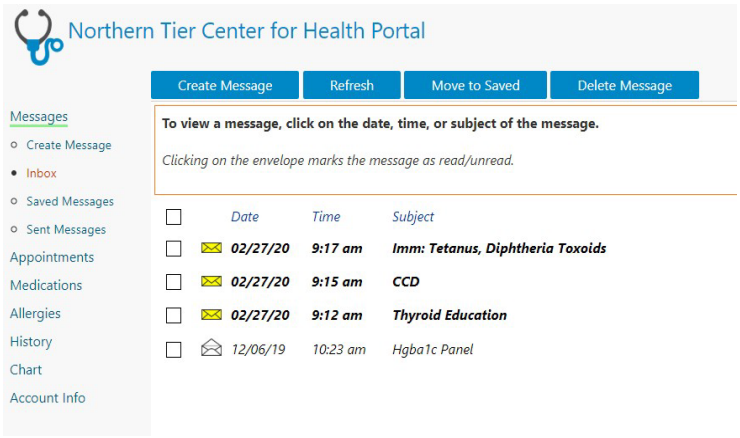
NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

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...





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.

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

NOTCH
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.