North Country Hospital
Where caring runs deep.

Health Information Management
Phone: 802-334-3266
Fax: 802-334-4105

ACCT#________ MR # ________ REQUEST DATE: ________ EXP DATE: ________

## Protected Health Information Release Authorization

Full Name: ____________________ Date of Birth: ____________

Address: ____________________ Phone #: ____________

This will authorize **North Country Hospital & Medical Practices**

Address: **189 Prouty Drive, Newport, VT 05855** Phone #: **802-334-3266**

to disclose my protected health information to ____________________

____________________

**PURPOSE:**
Transfer of Care / Coordination of Care / Sharing Care for Seasonal / Other____________

Dates of care include: ____________ to ____________

| Type of Information Requested | |
|---|---|
| **HOSPITAL RECORD** | **PHYSICIAN OFFICE RECORD** |
| Hospital Abstract (includes any available documents below OR check only those documents needed) | Clinical Abstract (includes any available documents below OR check only those documents needed) |
| ☐ Discharge Summary ☐ Lab Results ☐ Path Report<br>☐ History & Physical ☐ EKG Report ☐ Consultation<br>☐ Operative Report ☐ ED Report ☐ ALL<br>☐ Radiology Report ☐ Other: | ☐ Office Notes ☐ Problem Lists<br>☐ Medication Lists ☐ Immunizations<br>☐ Lab/Radiology Reports ☐ ALL<br>☐ Other: |

Please be advised that information, if any, regarding the following areas of treatment could be included in the records: behavioral/mental health services, HIV/AIDS related illness, drug / alcohol abuse treatment, and genetic testing. To withhold any of such records, please specify which____________________.

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that North Country Hospital shall not refuse to treat me if I refuse to sign this authorization.
- I understand that I have the right to revoke this authorization at any time, although the revocation will not be effective to previously released protected health information pursuant to a valid authorization. If I revoke this authorization, I must do so in writing addressed to: North Country Hospital, Health Information Management, 189 Prouty Drive, Newport, VT 05855.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and may no longer be protected by federal and state privacy regulations.
- I understand that I may be charged a fee for copies in accordance with state and federal law.

X____________________
Signature of Patient or Legal Representative

X____________________
Date

X____________________
Printed Name of Patient or Legal Representative

____________________
Relationship to Patient (if signed by Legal Representative)
(Attach copy of documentation of Authority to Act for Patient)

EXPIRATION DATE: This authorization will expire on (no later than one year from today) ____________ (If no date is stated, this authorization expires one year from the date it was signed.)

Page Count: ________ Date Released: ____________ Method of Release: ____________