

Northeastern Vermont Regional Hospital
1315 Hospital Drive
St Johnsbury VT 05819

MRN: _____
Name: _____
Date of Birth: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Page 2 of 2

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Phone # _____

PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent to, or information you would like sent from.

Information to: Pick up Send out **Date of Request:** _____ **Date Needed:** _____

Receive information from:
 Send information to:
St. Johnsbury Pediatrics
97 Sherman Drive
St. Johnsbury, VT 05819
Phone: 802-748-5131 / Fax: 802-748-4237

Receive information from:
 Send information to:
Name: _____
Address: _____
Telephone Number: _____
Fax Number: _____

Purpose for Release:

- Current Treatment Personal Records Insurance Worker's Compensation
 Attorney/Legal Claim Provider Transfer Disability Other (please specify): _____

INFORMATION TO BE RELEASED (please check all that apply and specify dates):

- Hospital Abstract (e.g. History & Physical, Consult Notes, Progress Notes, All Clinical Charts, etc.)
 Discharge Summary
 Operative Report, Test Results, Discharge Summary) Clinic Visit Notes
 Lab Reports Radiology Reports
 Operative Reports Radiology Images
 Pathology Reports ED Report
 Immunizations Medication List
 Physical, Occupational, Speech Therapy Notes
 Other (please specify): _____

Dates of Care to be Released: _____ to _____

Information Released/Reviewed by: _____ Date: _____

For office use only.

Identification verified by: _____ **Date:** _____

NORTHEASTERN VERMONT REGIONAL HOSPITAL
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Authorization to Disclose Protected Health Information

Page 1 of 2

1. I AUTHORIZE NORTHEASTERN VERMONT REGIONAL HOSPITAL AND ITS AGENTS TO RELEASE THE REQUESTED PROTECTED HEALTH INFORMATION TO OR RECEIVE PROTECTED HEALTH INFORMATION FROM THE PARTIES LISTED ON PAGE 2 OF THIS DOCUMENT.
2. By signing this form I am certifying that I am the patient or, a legally authorized representative (Health Care Agent Legal Guardian, Executor, etc.
3. I understand that if the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, my request for information will be submitted for processing.

I understand that:

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health services, and treatment of alcohol or drug abuse. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance use disorder records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
- I may be charged a fee for copies in accordance with the state and federal law.
- I have a right to revoke this authorization at any time by submitting a written request to the Department or Office where I originally submitted it. My revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health services at Northeastern Vermont Regional Hospital.

Expiration of Authorization:

I understand that this authorization will expire on _____ (insert expiration date). If I do not specify an expiration date, this authorization will expire 1 year from the date I signed the authorization.

Signature of Patient/Legal Representative

Date

Print Name

Relationship to Patient
(If signed by Legal Representative)

Please Return to:
St. Johnsbury Pediatrics
97 Sherman Drive
St. Johnsbury, VT 05819
Phone: 802-748-5131 / Fax: 802-748-4237