Choosing Health
NORTHEASTERN VERMONT REGIONAL HOSPITAL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth	MRN# *(if known)*
Patient Address		

I authorize Northeastern Vermont Regional Hospital to disclose my protected health information as described in this authorization.

I understand that:

- This authorization may include sensitive health information, such as mental health, substance use, or HIV-related information, if applicable.
- I may be charged a fee for copies of my records as permitted by law.
- I may revoke this authorization at any time by submitting a written request, except for information already disclosed.
- Information disclosed under this authorization may no longer be protected by privacy laws once released.
- Signing this authorization is voluntary and is not required to receive treatment or services.
- This authorization will expire on _____. If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.

PERMISSION TO SHARE MY HEALTH INFORMATION

Please tell us where you want your records sent or where you want us to request records.

☐**Send my records to:**

☐**Get records from:**

Name or Organization:	
Address:	
Phone #	Fax#
Delivery method ☐ Pick up ☐ Mail ☐ Electronic	

Purpose for Release:

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

Choosing Health
NORTHEASTERN VERMONT REGIONAL HOSPITAL

Description of the Information to be released/obtained:
The date of service and type(s) of information to be released or obtained are as follows:

The records to be released will cover the time period from _____to_____

Records from a specific Provider/Clinic: _____

☐ Discharge Summary ☐ Emergency Dept. Notes ☐ Inpatient Notes ☐ Immunizations
☐ Cardiology Testing Report ☐ Billing ☐ Laboratory Reports ☐ Radiology Reports
☐ Office or Clinic Notes ☐ Consults ☐ Operative Reports ☐ Radiology Images
☐ History and Physical ☐ Other: _____

This authorization includes the release of the following sensitive health information only if you place your initials next to the item(s) below:

_____ Mental health records *(including psychotherapy notes, where permitted)*

_____ HIV/AIDS–related information

Authorization to Discuss Health Information

By initialing here _____ I authorize_____
Initials Name of individual healthcare provider

To discuss my health information with the individual or entity identified above, as detailed in this Authorization.

By signing this form, you authorize Northeastern Vermont Regional Hospital and its agents to release or obtain your health information with the parties listed on this form.

_____ _____
Signature Date

If signed by parent or legal representative*:*

_____
Name/Relationship:

_____ _____
Signature Date