Northern Counties
HEALTH CARE

Authorization to Disclose Protected Healthcare Information (Instructions on back)

I, ____ *(Name of Patient – Please Print),* ________________ (*Date of Birth*), hereby authorize **Northern Counties Health Care (NCHC),** which includes the following Health Centers: Concord, Danville, Hardwick, Island Pond, Northern Express Care – St. J, and St. Johnsbury; and the following Dental Centers: Island Pond, Orleans, and Northern Counties, and its agents to:

Please check one: **[ ] Release to:** **[ ] Receive from:** **[ ] Release to and receive from:**

Name (of person/provider/program):____

Address: ____

City/State/Zip: ____________________________________ Phone #:________________ Fax #:__________________

Please read carefully and **check and/or describe the records you would like released/sent:**

[ ] **My FULL medical record with no limitations** on history of illness, or diagnostic and therapeutic information, ***including*** any treatment for alcohol or drug abuse*, mental/psychiatric impairments, HIV/AIDS-related illnesses, Hepatitis C, or genetic testing, etc.

OR

[ ] **My medical records EXCEPT for** (check or describe those items you ***do not want*** sent/released):
[ ] Drug or alcohol treatment* [ ] Mental/psychiatric illness [ ] HIV/AIDS-related illness [ ] Hep C [ ] Genetic Testing

[ ] Information pertaining to: ____

[ ] **Other notes about what to include or exclude:**____

____

Information to be disclosed for dates of care from: __________________(**Start Date**) to: __________________(**End Date**)

Purpose of disclosure (please check one)**:** [ ] Access to my records **OR** [ ] Insurance Claim **OR** [ ] Transfer of care **OR**

[ ] Other:____

Desired Format (please check one): [ ] Paper **OR** [ ] CD

I understand that:

- I have the right to revoke this authorization at any time. I must do so in writing and deliver/mail it to the Practice/Office Manager of the site where I am receiving care. Revocation will not apply to the information that has already been released in response to this authorization or other action that has been taken in reliance on an authorization I have signed.
- Information used or disclosed pursuant to this authorization could be subject to re-disclosure by recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- NCHC may not condition treatment on my signing this authorization and that I may refuse to sign this authorization.
- *I understand that federal regulations (42CFR part 2) prohibit the disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations.

^This authorization will expire on __________________. If no date or event is stated, expiration is effective six months from the date below.

____ _____________________________________
(Signature of Patient or representative) (Date)

____ _____________________________________
(Print Name) (Relationship to patient)

Instructions for Authorization to Disclose Protected Healthcare Information on reverse side.

1. **PLEASE TELL US WHO THE PATIENT IS.**
   Name of Patient **and** ***Date of Birth:*** Please print the name of the patient and the patient's Date of Birth, even if the person filling out the form is not the patient.

2. **PLEASE TELL US IF YOU WANT NCHC TO SEND RECORDS OUT AND/OR DO YOU WANT NCHC TO BE SENT RECORDS.**
   Please check **[ ]** ***Release to*** if you want NCHC to send records.
   Please check **[ ]** ***Receive from*** if you want records sent to NCHC
   Please check **[ ]** ***Release to and receive from*** if you want records sent from NCHC and to NCHC.

3. **PLEASE TELL US WHERE TO SEND THE RECORDS OR WHO WILL BE SENDING THE RECORDS TO NCHC.**
   Name (of person/provider/program): You must identify the name of the person or program sending or receiving the information. Fill in as much of the contact information as possible.

4. **PLEASE TELL US WHAT RECORDS YOU WANT SENT.**
   Please check ***[ ] My FULL medical records*** if you want your **entire** medical record, without restriction, sent.
   OR
   Please check *[ ]* ***My medical records EXCEPT for*** if you want certain information not to be sent – then please check off or describe the information you **do not want to be included**.
   - If there are only certain records you want sent or certain items you want to exclude, please describe.

5. **PLEASE TELL US THE DATE RANGE OF THE RECORDS TO SEND.**
   Information to be disclosed for dates of care from: ______________(Start Date) to: _______________(End Date)
   (Start Date) is the beginning of the date range, for example your date of birth.
   (End Date) is the last date for which records should be sent, for example the same day that you signed this form.

6. **PLEASE TELL US WHY THE RECORDS ARE NEEDED.**
   Please check ***[ ] Access to my records*** if you want your records yourself.
   Please check ***[ ] Insurance Claim*** if you want the records for an insurance claim.
   Please check ***[ ] Transfer of care*** if you want the records transferred to another place because you are discontinuing care at NCHC.
   Please check ***[ ] Other*** and briefly state if you want the records for some other reason such as "FOR COURT."

7. **PLEASE TELL US IF YOU WANT THE RECORDS ON PAPER OR ON A CD.**
   [ ] Paper OR [ ] CD

8. **PLEASE TELL US HOW LONG THIS AUTHORIZATION IS VALID. For example, do you want it to last for one year?**
   If you do not write in a date, then it will be valid for 6 months from the date on the form. After that, we cannot provide your records without a new Authorization.
   **This authorization will expire on ___________________. If no date or event is stated, expiration is effective six months from the date below.*

9. **WE NEED THE PATIENT TO SIGN IF THE PATIENT IS ABLE TO. If the patient is under the age of 18 or is not able to sign the form, then a person representing the patient may sign for the patient. We need to know how you and the patient are related, and we may need to ask for legal documentation, such as a court order or guardianship papers.**

____	_________________________________
(Signature of Patient or representative)	(Date)
____	_________________________________
(Print Name)	(Relationship to patient)