Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____DOB: ______________________

MRN#: ______________________Last 4 SS#: ____________ Phone #: __________________________

Address: ____

____

All sections of this form must be filled out completely or it will not be accepted.

I hereby authorize Mt. Ascutney Hospital & Health Center (MAHHC), including the Ottauquechee Health Center, to disclose my health information as described below, **which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable (excludes psychotherapy during a private counseling session or a group, joint or family counseling).** I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a HIPAA covered entity, the disclosed information may no longer be protected by federal and state privacy regulations.

Purpose of Request: ____

____

Description of information to be **disclosed or obtained from other provider/facility:**

Inpatient dates: ____
Outpatient dates or provider name: ____
Itemized Billing Records dates:____
Include photos? YES NO (please circle)

The health information shall be **disclosed to/obtained from:**

____
Name

____
Address

____
City State Zip Code

I authorize my provider(s) at MAHHC to speak with my health care provider(s) at other facilities.

I understand that I may be charged for copies of my medical records. (See reverse side for fees)

I understand this authorization will expire **six (6)** months from the date of this authorization unless I otherwise specify (Alternative date if desired):____

I further understand that I may revoke this authorization at any time by notifying MAHHC in writing at 289 County Rd., Windsor, VT 05089, except to the extent it has already been relied upon.

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Dartmouth-Hitchcock

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Patient Name: ______________________________________DOB: _____________________________

MRN#: ______________________Last 4 SS#: ____________ Phone #: __________________________

If for my own personal use, I request that my records be:

Emailed to me at: ____

Mailed to on paper me at: ____

Saved on a CD and mailed to me at: ____

____

I understand if I request to have my records emailed to me, this is not a secure method and Mt. Ascutney Hospital and Health Center is not responsible for any misuse of my records. **INITIAL HERE** ________

____

Signature of Patient or Personal Representative **Phone Number** **Date**

____

Printed Name of Personal Representative Legal Authority of Personal Representative

Fax Numbers:
Hospital HIM: 802-674-7152
Physicians' Practices: 802-674-7314
Emergency Room: 802-674-7006
Acute Floor: 802-674-7005
Ottauquechee Health Center: 802-457- 2157
Rehabilitation Unit: 802-674-7150
Radiology: 8026747-7099
Specialties:
    Podiatry: 802-674-7004
    Physiatry: 802-674-7388
    GI/General Surgery: 802-674-7475
    Windsor Ophthalmology: 802-674-7346
    Hanover Ophthalmology: 603-643-1877

Phone: HIM Dept.: 802-674-7254