FIVE-TOWN HEALTH ALLIANCE, Inc.
DBA Mountain Health Center/Mountain Health Dental Care
74 Munsill Avenue, Suite 100
Bristol, VT 05443
Phone: 802-453-5028 Fax 802-453-6105

UNIFORM CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient:_____ Date of Birth:_____
(First name) (Middle Initial) (Last Name)
Address:_____ City:_____ State_____ Zip_____

I understand that it may be necessary for Mountain Health Center or Mountain Health Dental Care (MHC) to share my Protected Health Information (PHI) with other healthcare professionals and other individuals and entities for the purposes of my treatment, coordination of my care, referral to other treatment facilities, practice operations, processing and payment of claims, obtaining prior authorization for services, or resolving any legal or administrative issues as directed by me.

I agree that my PHI may include all of the following: My complete medical history, diagnoses, medications, progress notes, counseling notes, psychologic assessments, diagnostic test results (including drug testing), nursing notes, internal and external correspondence regarding my medical conditions, notes from other healthcare professionals to whom I may be referred, any of my prior medical records in MHC's possession, and all information on mental health conditions, drug and alcohol substance use disorders, and AIDS/HIV status.

I give permission to MHC to share my PHI, including all information listed under Paragraph 2 above, with me and with:

1. All clinical and administrative staff employed by MHC who need to have access to my medical records.
2. My health insurance company for claims payment purposes.
3. The following family members, guardian, power of attorney, or executor (name, address, relationship):_____
   _____
4. The following healthcare professionals with whom I have an existing relationship or to whom I may be referred for treatment: University of Vermont Health Network and its affiliated medical practices, Addison County Home Health and Hospice, Counseling Services of Addison County, Rutland Mental Health Services, Dartmouth-Hitchcock Medical Ctr., Rutland Regional Medical Ctr., the assisted-living facility or nursing home where I reside, my pharmacy, my school nurse, VT Sleep Ctr., VT Gastroenterology, 4 Seasons Derm., my physical therapist and my chiropractor.
5. Any other individual or entity (identify individual recipient when possible) designated by me here (name, address, phone number):_____
   If #5 above is filled in, are you transferring care out of Mountain Health Center? Yes or No

I give permission to MHC to obtain copies of my PHI from my previous healthcare providers, including all information listed under Paragraph 2 above (name, address, phone number):_____
_____

I understand that this Consent is voluntary and can be revoked by me in writing at any time. I understand that any revocation shall not be effective to the extent that action has already been taken in reliance on this Consent.

I understand that this Consent shall expire when I am no longer a MHC patient, unless I elect to revoke it at an earlier date. I understand the terms of this Consent.

The confidentiality of substance use disorder patient records is protected by Federal regulations (42 CFR Part 2), which prohibit any person or entity named above from making further disclosure of this information unless such disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2.

Patient Signature:_____ Date:_____

Guardian or Legal Representative's Signature:_____

Print Representative's Name:_____ Relationship to Patient:_____ Phone_____