16181

Vermont
Consent for Viewing My Health Information

Patient Last Name:

First Name: Suffix:

Middle Name: Gender: O Female O Male

Date of Birth: / /

Home Phone: - - Mobile Phone: - -

Street Address:

City: State: Zip:

Your signature on this form indicates acceptance of the following.

I give my consent to Little Rivers Health Care, Inc.
(Participating Health Care Provider) to access and use or disclose my protected health information, including mental health, and substance abuse treatment information, on the Vermont Health Information Exchange (VHIE) and the Blueprint for Health Integrated Health Record for my treatment, for payment for my treatment, and for health care operations consistent with the federal HIPAA privacy regulations and Vermont law.

I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health benefits program to Participating Health Care Provider for the purpose of my treatment.

My consent includes the re-disclosure of protected health information received from a drug or alcohol treatment program for my treatment.

I have been referred to Vermont Information Technology Leaders, Inc. (VITL), for information regarding the VHIE and am aware that I can request information regarding the privacy practices of my Participating Health Care Provider as described in its Notice of Privacy Practices.

I understand I do not have to give my consent in order to receive treatment from the Participating Health Care Provider.

This consent is subject to my revocation (termination) at any time except to the extent that my protected health information obtained from the VHIE has already been accessed by the Participating Health Care Provider and included in its medical record.

If not previously revoked, or otherwise stated, my consent will terminate when the Participating Health Care Provider receives notice that I will no longer be a patient.

_____ / / _____
Signature of Patient (If Patient is 12 years or older) Date

_____
Signature of Parent or Authorized Representative
(If Patient is under the age of 18 or Patient is incapacitated)

_____ _____
Name of Parent or Authorized Representative (please print) Relationship to Patient

For Office Use Only:

MRN:

_____
Verifier

Vermont Consent Fax Line: 888-240-9643

1 3 1 6 1 6 5 1 2 9

V1.1