



A Dartmouth-Hitchcock Affiliate

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

Patient Name: _____ DOB: _____ MRN: _____

Address: _____ Phone No: _____

Purpose of the use and/or disclosure: Pre-employment immunization review.

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

I hereby authorize Mt. Ascutney Hospital & Health Center to **obtain** my individually identifiable health information as described below. 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 covered entity, such as insurance company or health care provider, the disclosed information may no longer be protected by federal and state privacy regulations.

Description of information to be **disclosed**:

- Influenza vaccination documentation, PPD & Quantiferon Gold test results.

The health information shall be **disclosed to**:

<u>MAHHC Employee Health</u>	<u>289 County RD</u>	
Name	Address	
<u>Windsor</u>	<u>VT</u>	<u>05089</u>
City	State	Zip Code

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

Signature of Patient or Personal Representative Phone Number Date

Printed Name of Personal Representative Legal Authority of Personal Representative