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:**

__MAHHC Employee Health_______________________________________ 289 County RD______________________________
Name Address

_Windsor____ VT_____________________________ 05089_________
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

Fax: Mt. Ascutney Hospital Employee Health- (802)674-7181
8/2016