Community Health Center
of the North Country

Consent to Discuss Protected Health Information (PHI)

Patient's Name:_____DOB:_____

Protected Health Information (PHI) means individually identifiable information relating to past, present, or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

Healthcare Treatment consists of services provided by each discipline within CHCNC: Primary, Mental Health, Dental, Optometry, Physical Therapy, Orthopedic, and Foot Care.

This consent is limited, and does not include permission to discuss Alcohol/Drug Treatment or confidential HIV/AIDS –related information, which needs a special signed release.

I give permission to CHCNC to discuss my PHI (or the PHI of above named patient I am authorized to consent for) with the following individuals:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

I understand I have the right to revoke these permissions, in writing, at any time, except in regards to actions the Health Center has already taken due to this consent.

Patient/Guardian Signature: _____ Date:_____

Printed Name:_____

Relationship (if applicable):_____