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):_____

Permission to Accompany

Patient's Name:_____DOB:_____

The following individual(s) have my permission to accompany the above named minor child to a healthcare appointment at Community Health Center of the North Country. I understand that this person will be privy to PHI. I understand that if an invasive procedure is needed I will need to bring the child in or be available for telephone consent.

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

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I understand I have the right to revoke these permissions, in writing, at any time, except to the extent that the Health Center has already taken action in reliance on this consent.

Patient/Guardian Signature: _____ Date:_____

Printed Name:_____

Relationship (if applicable):_____