586 Oak Hill Road Williston VT 05495 (802) 878-8131

Consent to Release Protected Health Information

to Family and Friends

Patient name:_____

Patient DOB:_____

I give permission for Thomas Chittenden Health Center to share my medical information with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care.

The information may be shared in the following ways (check all that apply):

___ Verbal discussions, either in person or by telephone
___ Written or electronic information (lab results, letters, progress notes)
___ Portal access through Authorized Representative

Name/relationship of persons to receive access to medical information:

_____

_____

_____

I understand that I have the right to revoke my permission at any time, and that this permission remains in effect until the time I revoke it *in writing*.

Signature of patient:_____

Date signed:_____