



Patient Request to View Protected Health Information in the Vermont Health Information Exchange

_____/_____/_____
Patient name (Last, First, MI) (please print) Patient birthdate

Patient address (Street, City, State, Zip code)

Patient Phone Number (Home) Patient Phone Number (Cell / Alternate) Last 4 digits of Social Security #

An individual shall be provided the right of access to his or her protected health information available on the Vermont Health Information Exchange through Vermont Information Technology Leaders, Inc. **The identity of the person named above, or the person's authorized representative, must be verified by a Notary Public.** Please note that this is a two-page form: use page two when verifying identity by notary public.

I wish to view my protected health information on the Vermont Health Information Exchange, starting on _____ and ending _____.
Start Date End Date

Signature of Patient or Authorized Representative Date

Name of Authorized Representative (please print) Relationship to Patient

Authorized Representative address, if different from patient (Street, City, State, Zip code)

Authorized Rep. Phone Number (Home) Authorized Rep. Phone Number (Cell / Alternate)

Verification by Notary Public

Instructions for Notary Public: Before signing below, examine government photo ID to verify identity of Patient or Authorized Representative.

STATE OF _____

COUNTY OF _____, ss.

At _____, this _____ day of _____, _____ personally appeared, and he acknowledged this instrument by him sealed and subscribed, to be his free act and deed.

Before me, _____
Notary Public

My Commission Expires: _____
Date

Send completed form including notary public verification to:

Vermont Information Technology Leaders, Inc.
C/O Privacy Officer
1 Mill Street, Suite 249
Burlington, VT 05401

For more information or questions about this form, contact VITL toll-free at 888-980-1243