

Porter Medical Center

Helen Porter Rehabilitation & Nursing

Application for Admission

Applicant

Last Name: _____ First Name: _____ MI: _____

Sex: M F Marital Status: _____ DOB: _____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

Advanced Directive? Yes No Social Security Number: _____

Primary Representative

Name: _____ Relationship: _____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

E-mail: _____ Phone (Work): _____

Is there a court-appointed guardian? Yes No If so, date appointed: _____

Is a guardian being recommended/in process?: Yes No

Power of Attorney? Healthcare: Yes No Finances: Yes No

Secondary Representative

Name: _____ Relationship: _____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

E-mail: _____ Phone (Work): _____

Alternate Power of Attorney? Healthcare: Yes No Finances: Yes No

***** Attach copies of all advanced directives, powers of attorney, and documents establishing guardianship.*****

Primary Care Provider: _____ Phone: _____

Practice: _____ Fax: _____

Address: _____

Primary Diagnosis: _____

Allergies or Other Concerns: _____

Is admission requested for? Long-term Care Memory Care Respite Stay (less than 30 days)

Reason(s) for admission: _____

Has the applicant been hospitalized or in a skilled nursing facility in the past 60 days? Yes No

Date From: _____ Date To: _____

Facility: _____ Phone: _____

Address: _____ Fax: _____

Reason(s): _____

Financial Information

Medicare Number: _____ Part A: Yes No Part B: Yes No

Other Insurance

Company: _____ Phone: _____

Policy: _____ Group: _____

Policy Type: Traditional Insurance Medicare Supplement Medicare Advantage

Medicare Part D or Prescription Coverage

Company: _____ Phone: _____

Policy: _____ Group: _____

Long-Term-Care Insurance

Company: _____ Phone: _____

Policy: _____ Group: _____

Medicaid

Number: _____ State: _____ County: _____

Is a Medicaid application pending? Yes No In progress? Yes No

Are you interested in knowing more about Medicaid? Yes No

***** Attach copies of both sides of all policy membership cards. *****

Printed Name: _____

Signature: _____ Date: _____

Office Use Only

Received By: _____ Date of Receipt: _____

The University of Vermont Health Network -Porter Medical Center
PATIENT AUTHORIZATION - MEDICAL INFORMATION

Your medical records cannot be released or obtained until this form is completed and signed by the patient or legal representative. Requests for copies of medical records are subject to reproduction fees in accordance with applicable law.

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

I hereby authorize _____ to take the following action:
UVM Health Network PMC (Facility)

- Provide a copy of my protected health information (PHI) to me.
- Release my PHI to:
- Discuss my PHI with:
- Obtain copies of my PHI from:

Person or Entity: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax: (Health care provider only) _____

Purpose for releasing information: Continuation of care Personal Transfer of Care Insurance Legal

I authorize the following PHI to be released: Office Notes (PCP) Continuation of Care documents Lab Radiology
 Immunization records Medications ER record Complete Medical Record (all pages)
 Abstract (includes History and Physical, Operative report(s), Consultation(s), test result(s) and Discharge Summary)
 Other: _____ Dates of Service: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, treatment for mental health related issues, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate)

Alcohol, Drug, or Substance Abuse Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: _____
HIV Testing and Results	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: _____
Mental Health Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: _____
Psychotherapy Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: _____
Genetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: _____

By signing this authorization form, I understand that: Federal confidentiality rules (42CFR Part 2) prohibit the recipient of my health information from re-disclosing any of my federally protected drug and alcohol treatment information without my express written consent or as allowed by the regulations. I also understand that under Vermont statute, my health information can only be disclosed with my authorization/consent or as mandated by and express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all health information (other than my federally protected drug and alcohol treatment information) used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 and Vermont Law.

- I have the right not to sign this authorization
- My medical treatment is not dependent upon signing this authorization.
- I have the right to inspect or copy the information disclosed and I have the right to obtain a copy of this authorization.
- I have the right to revoke this authorization at anytime. Revocation must be in writing and sent to the Health Information Management Department , 115 Porter Drive, Middlebury, VT 05753 (revocation will not apply to information that has already been released in response to this authorization.)
- Unless otherwise revoked, this authorization will expire on the following date: _____
- If I fail to specify an expiration date, this authorization will expire in six (6) months.

Patient or Legal Representative Signature

Date

Relationship

(For office use only) – Medical Record Number _____ Date completed _____ Initials _____