



Good Neighbor Health Clinic  
Red Logan Dental Clinic

70 North Main Street  
White River Junction, VT 05001  
Medical Fax: (802) 295-3600  
Dental Fax: (802) 359-1020  
Medical Clinic: [medical@goodnhc.org](mailto:medical@goodnhc.org) Phone: (802) 295-1868  
Dental Clinic: [dental@goodnhc.org](mailto:dental@goodnhc.org) Phone: (802) 295-7573  
Website: [www.goodneighborhealthclinic.org](http://www.goodneighborhealthclinic.org)

Good Neighbor Health Clinic and Red Logan Dental Clinic serve patients who meet all of the following criteria:

1. **Are 18 years and older**
2. **Live in one of the following towns:**

**Vermont:** Barnard, Bradford, Bridgewater, Corinth, Fairlee, West Fairlee, Hartland, Hartford, Newbury, Norwich, Pomfret, Reading, Royalton, Sharon, Strafford, Thetford, Topsham, Tunbridge, Vershire, Windsor, West Windsor, Woodstock

**New Hampshire:** Canaan, Claremont, Cornish, Croydon, Dorchester, Enfield, Grafton, Grantham, Hanover, Lebanon, Lyme, Newport, Orange, Orford, Plainfield, Springfield

Please provide proof of residency (driver's license or utility bill) with this application. Let us know if you are unable to provide this.

3. **Have a household income up to 300% of the Federal Poverty Limit**  
Help us understand your household income with the following information:

How many dependent children under age 18 live in your home? \_\_\_\_\_

How many family members total are living in your household?  
(You + spouse/partner + dependent children under age of 18 living at home) \_\_\_\_\_

**Household Income (before tax and withholding)**

**Per Month:**

Your Income \$ \_\_\_\_\_

Spouse/Partner Income \$ \_\_\_\_\_

Other income (disability income, child support, or public assistance) \$ \_\_\_\_\_

**Total household income (before tax)** \$ \_\_\_\_\_

Please provide proof of income (Pay Stub, W-2, Social Security Statement, Disability Income, Child Support, Public Assistance or other income) with this application. If you do not have a bank account or cannot provide these, please let us know.

*I agree the information provided on this form is accurate. I give Good Neighbor Health Clinic permission to verify information (including income, residency and insurance status) contained on this form.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

☐ (Internal use only) Per discussion with patient, no proof available

I am applying to the (check all that apply):

☐ Dental Clinic

☐ Medical Clinic

Note that applications are renewed annually. We will send a reminder when you are due.

**What is your main goal for receiving care here?** \_\_\_\_\_

**Patient Information**

Last Name: \_\_\_\_\_ Legal First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred name: \_\_\_\_\_

Date of Birth (month/day/year): \_\_\_\_\_ Age: \_\_\_\_\_ SSN \_\_\_\_\_

Race: \_\_\_\_\_ Languages spoken at home: \_\_\_\_\_

**Pronouns:**

- ☐ She/her
- ☐ He/him
- ☐ They/them
- ☐ Write in: \_\_\_\_\_

**Relationship Status:**

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ In a relationship, not married

**Gender assigned at birth:**

- ☐ Female
- ☐ Male
- ☐ Intersex

**Gender identity:** \_\_\_\_\_ **Sexual identity:** \_\_\_\_\_

**Education and Employment Information**

**Highest Level of School Completed:**

- ☐ Less than high school diploma. Grade: \_\_\_\_\_
- ☐ High school diploma or GED
- ☐ Some college, but no degree
- ☐ Associate's Degree (such as AA, AS)
- ☐ Bachelor's Degree (such as BA, BS)
- ☐ Master's Degree, Professional Degree or Doctorate (such as MA, MD, PhD)

**Employment Status:**

- ☐ Full time
- ☐ Part-time
- ☐ Self Employed
- ☐ Seasonal/Temp
- ☐ Unemployed
- ☐ Retired
- ☐ Disabled

If employed, where? \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is it okay for us to call you at work? ☐ Yes ☐ No

Have you served 2 or more years in the Military? ☐ Yes ☐ No If yes, what branch? \_\_\_\_\_

**Contact Information:**

Home phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email Address:\_\_\_\_\_

What is the best way for us to contact you?    Home    Cell    Work    Email    Other:

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Mailing Address:\_\_\_\_\_

Town:\_\_\_\_\_ State: \_\_\_\_\_ Zip Code:\_\_\_\_\_

Physical Address:\_\_\_\_\_

Town:\_\_\_\_\_ State: \_\_\_\_\_ Zip Code:\_\_\_\_\_

**Health Related Needs:**

Housing Status:    ☐ Rent    ☐ Own    ☐ Temporary Housing    ☐ Unhoused

Transportation Status:    ☐ Have a car    ☐ Stable access to car    ☐ Public transit    ☐ None

Have you ever run out of food by the end of the month?    ☐ Yes    ☐ No

Have you ever worried about running out of food?    ☐ Yes    ☐ No

Do you smoke or chew tobacco?    ☐ Yes    ☐ No    If yes,    ☐ Smoke    ☐ Chew    ☐ Vape

Are you interested in quitting smoking?    ☐ Yes    ☐ No

**Medical Information:**

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Do you have health insurance? ☐ Yes ☐ No

If yes, what type?  
☐ Medicare  
☐ VT Medicaid  
☐ NH Medicaid  
Write in: \_\_\_\_\_

Do you have dental insurance? ☐ Yes ☐ No

If yes, what type?  
☐ Medicare  
☐ VT Medicaid  
☐ NH Medicaid  
Write in: \_\_\_\_\_

Do you have Medicare Part D (prescription drug coverage?)

☐ Yes ☐ No

Do you have a Primary Care Provider (outside of Good Neighbor Health Clinic?)

☐ Yes ☐ No

If yes, please provide name of Provider:

\_\_\_\_\_

Have you delayed getting care or medications because of the cost?

☐ Yes ☐ No

Where would you go for medical care if you could not come here?

☐ Emergency Dept. at hospital  
☐ Another doctor  
☐ I wouldn't have gone  
☐ I don't know

How did you hear about us? \_\_\_\_\_

## Medical History Form

**Patient Name:**

**Date of Birth:**

**Today's Date:**

To the best of my knowledge, I will answer the questions on this form accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the medical and/or dental office of any changes in health status.

Signature: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes \_\_\_\_\_

Are you:

☐ Pregnant

☐ Nursing

☐ Taking oral contraceptives

Are you allergic to the following?

☐ Aspirin

☐ Penicillin

☐ Sulfa Drugs

☐ Acrylic

☐ Metal

☐ Latex

☐ Codeine

☐ Local Anesthetics

☐ Other: \_\_\_\_\_

Comments:

Have you ever had any of the following diagnoses or events?

|                      |                              |                             |                     |                              |                             |
|----------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| AIDS/HIV Positive    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Pacemaker     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Valve Problem  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis A         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Transfusion    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis B or C    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Renal Dialysis      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| COPD                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack/Failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizure             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you currently have or have you had in the last 30 days any of the following symptoms?

|                                        |                              |                             |                           |                              |                             |
|----------------------------------------|------------------------------|-----------------------------|---------------------------|------------------------------|-----------------------------|
| Breathing Problems                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anaphylaxis               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pains                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting spells/Dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold Sores/Fever Blisters              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain in Jaw Joints        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prolonged bleeding when brushing teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recent Weight Loss        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes:



Good Neighbor Health Clinic  
Red Logan Dental Clinic

## Health Confidence Survey

What do you do to stay healthy?

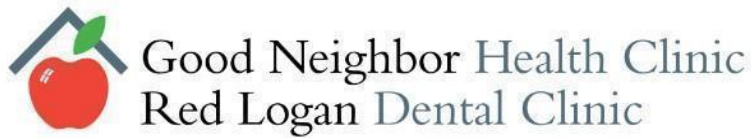
What do you do when your health is getting worse?

Do you have a support system that helps you manage your health?

☐ Yes

If yes, who? \_\_\_\_\_

☐ No



## PATIENT RESPONSIBILITY NOTICE

Effective July 2026

It is your responsibility as a patient of Good Neighbor Health Clinic and Red Logan Dental Clinic to:

Please read and initial:

- 1. Keep ALL scheduled appointments** - If you cannot keep a scheduled appointment, you must inform us before the appointment as early as possible as there are others who also need appointments \_\_\_\_\_
- 2. Arrive 10 minutes early for appointments** - If you arrive 15 minutes or more after your scheduled appointment time, we will need to reschedule your appointment. \_\_\_\_\_
- 3. Confirm your appointments** - We will give you a call one business day before your appointment. If we leave you a message, you must call us back to confirm. Unconfirmed appointments will be cancelled. \_\_\_\_\_
- 4. Respect Staff** - You must treat all staff, visitors and the clinic property in a calm, respectful manner. Yelling, bad language, behavior that is disrespectful to staff or other patients and threats of any kind will not be tolerated and may result in dismissal as a patient. \_\_\_\_\_

3 missed appointments over 3 months without 24 hour business notice will result in cancellation of all future appointments and you will be unable to make appointments for up to 6 months. Exceptions will be made at our discretion for illness, emergencies, etc.

We understand that true emergencies happen and those situations will be handled accordingly.



**Good Neighbor Health Clinics**

**FREE CLINICS FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM**

**Patient Notice of Limited Liability of**

**FTCA Deemed Volunteer Free Clinic Health Care Professionals**

**Malpractice coverage for the Good Neighbor Health Clinics is provided by the  
Federal Government**

**Details:**

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401 (b ), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)). Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

Acknowledged: \_\_\_\_\_ (patient signature)

\_\_\_\_\_ (patient name, printed legibly)

Date: \_\_\_\_\_

## Telephone Consumer Protection Act (TCPA) Agreement

Will you allow Good Neighbor to use an automated system to give you appointment reminder texts/calls before your appointments? This applies to the medical clinic only. If so, please read and sign below:

I \_\_\_\_\_ (or my guardian/legal representative) agree to be contacted by Good Neighbor Health Clinic (GNHC) and others on its behalf by telephone calls made by or using an automated dialing system or pre-recorded messages at the number(s) provided in this Application, for all non-marketing purposes. I (or my guardian/legal representative) agree to notify GNHC promptly if any of my numbers or addresses change in the future. I (or my guardian/legal representative) understand that this consent is not required, or a condition of purchase and it can be revoked at any time. By providing a phone number and signing below, I acknowledge that I have read and agree to the TCPA Communication Consent above.

- ☐ I agree to receive SMS/text reminders 24 hours prior to appointment (cell phones only)
- ☐ I agree to receive voice reminders 24 hours prior to appointment (voice will only be used as a fall-back if no cell # is on file or if SMS/text is failing)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Good Neighbor Health Clinic  
Red Logan Dental Clinic

ACKNOWLEDGE RECEIPT OF PRIVACY PRACTICES

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\*You may refuse to sign this acknowledgement

I, \_\_\_\_\_, have seen and was offered a copy of this office's Notice of Privacy Practices.

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Please Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

**Good Neighbor Health Clinics  
70 North Main Street  
White River Junction, Vermont 05001**

**Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND  
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

**PLEASE REVIEW IT CAREFULLY  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

**Our Legal Duty**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect July 27, 2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this notice.

**Uses and Disclosures of Health Information**

We use and disclose your health information for different purposes, including treatment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and other performance, conducting training programs, accreditation, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our

professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**SUD Treatment Information:** If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment or health care operations, we may use and disclose your Part 2 Program record for treatment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

**Secretary of HHS:** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation:** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement:** We may disclose your PHI for law enforcement purposes as permitted by HIP AA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities:** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if

efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

## **OTHER USES AND DISCLOSURES OF PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

## **Patient Rights**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice.

**Disclosure Accounting:** You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.

**Records Release:** All Good Neighbor Health Clinic and Red Logan Dental Clinic patients with a health record through Dartmouth Health consent to have records released to Good Neighbor Health Clinics if deemed necessary to provide high quality care.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf ( other than the health plan), has paid our practice in full. If we do agree to additional restrictions, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location.

**Amendment:** You have the right to request that we amend or correct your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach:** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice:** If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this notice in written form.

## **Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officers: Elizabeth Franson, MHA  
Telephone: 802-295-1868  
Fax 802-295-3600  
Email: [Elizabeth@goodnhc.org](mailto:Elizabeth@goodnhc.org)  
Address: PO Box 1250, White River Junction, VT 05001

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