Authorization to Disclose Health Information

I, _____, born on this date _____
(Name of person whose information is being requested)

do hereby authorize

_____
(Name & address of person/agency making the disclosure)

to disclose to

_____
(Name & address of person/agency receiving the disclosure)

the following information (circle Y for Yes or N for No for each type of information):

	Information Type		Information Type		Information Type
Y N	Attendance only	Y N	Behavorial Support Plans	Y N	Test Results
Y N	Presenting Issues/ Diagnosis	Y N	Medication Prescribed	Y N	AIDS/HIV Diagnosis or Treatment Information
Y N	Evaluations/ Assessment Summary	Y N	Progress Notes	Y N	Drug and Alcohol related information
Y N	Treatment Recommendations	Y N	Discharge Summary/Plan	Y N	Other (Specify):
Y N	Treatment Plan/Support Agreement	Y N	Entire Record	Y N	Other (Specify):

Time periods or other specifics related to the information to be disclosed: _____

_____

The purposed for this disclosure is: _____

_____

I understand that federal regulations (42 CFR part 2) prohibit the redisclosure of drug & alcohol treatment information without my written consent or as allowed by the regulations. I understand that under Vermont statute, my health information can only be disclosed with my authorization or as mandated by express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by this rule (Privacy Standards of the Health Insurance Portability and Accountability Act of 1996).

I understand that my treatment/support is not conditioned upon authorizing this disclosure. I understand I may revoke this authorization at any time except to the extent that the Agency, or other agency making disclosure, has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the Agency at the address above.

Date or event upon which this authorization will expire: _____. I understand if I do not note a date or event, then this authorization will expire one year from the date it was signed below.

Client's Signature: _____ Date: _____

Parent/Guardian
Or Legal Representative's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

Revocation of Authorization: I hereby revoke this authorization on _____(date) at _____(time). Do not disclose any further information under this authorization.

Signature: _____