Client # _____

Central Vermont Substance Abuse Services

Authorization to Disclose Protected Health Information

(For non-healthcare entities such as: disability determination & lawyers, and for all Releases of Substance Abuse Information)

I, _____born on this date _____
(Name of person whose information is being request

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	Y N	Diagnosis / Presenting Problem	Y N	Assessment Summaries / Evaluations
Y N	Treatment Recommendations	Y N	Medication Prescribed	Y N	AIDS/HIV Diagnosis or Treatment Information
Y N	Treatment Plan/Individual Plan of Care	Y N	Behavioral Support Plans	Y N	Progress Notes
Y N	Test Results (includes Lab Testing & Urine Tox Results)	Y N	Agency Discharge Summary/Plan	Y N	Entire Clinical Record
Y N	Drug and Alcohol Information	Y N	Other (Specify):	Y N	Entire Record Set (ie:non clinical billing and payment information)

Time period of the information to be disclosed: _____

_____

The purpose of this disclosure is:

_____

Means of Disclosure (check all that apply): o Paper o Oral o Electronic o Video o Audio Tape o Fax

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 an 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 the disclosure, has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the Agency at the address on following page.

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: _____

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

Signature:

See back for instructions

Client # _____

Central Vermont Substance Abuse Services is committed to and responsible for protecting the privacy of your health information. The information we ask from you on the front of this form will help us to fulfill this responsibility.

Name of person whose information is being requested: This is the name of the person that the Agency has provided services to and is keeping information on. This should not be confused with the individual or an individual's parent/guardian.

Birth Date: Along with your name we use your birthday as a means to identify you. On occasion we may ask for more information such as your social security number. We do this because some names are common and birthdays and social security numbers can be used to identify the right person.

Name and address of person/agency making the disclosure: This is the organization or person you are asking to disclose information about you. In most cases this will be the Agency but we could be asking for information from another provider. Be sure to include the address or we will not know where to send it.

Name and address of person/agency receiving the disclosure: We are asking who and where you want us to send the information. If the Agency is requesting the information then our name and address will be listed here.

Information: What kind of information do you want released? Circle Y for yes for each information type you want us to disclose. Circle N for no for the information types you DO NOT want us to disclose. You need to answer Y or N for each information type so we can make sure we are only releasing the information you wish.

Purpose of this disclosure: By telling us why you want this information disclosed, we can ensure we only release the minimum amount of information necessary to meet the purpose of this release. If you don't want to tell us, you can write, "At the request of the individual" in this section.

Means of Disclosure: Health information is kept in various way and we need to know in which way you want us to disclose it.

Date or event upon which this authorization will expire: Tell us when we should no longer release information about you. In most cases that will be after we have sent the information requested to the party you wanted to receive it. This authorization will automatically expire a year from the date you signed it unless you tell us an event or other date when it should end.

Signatures: In order for the Agency to honor your request, the authorization form must by signed by you if you are an adult or an emancipated minor. If you are an adult but have a legal guardian or representative they must sign this form. If you are under 18 years of age your parent/guardian must sign for you. However, if you are a minor who is 12 years of age or older and sought confidential drug/alcohol treatment under a physician's care then only you can sign this form not your parents or guardians. The Agency requires a copy of guardianship papers or documentation of legal representation in order to honor a release from a guardian or legal representative. All signatures must be dated. In order to protect your information we may ask you to provide identification to make sure you are you.

Revoking Authorization: If you decide to change your mind about disclosing this information in the future, you can take back your authorization. Call or stop in to complete this section. *This change would only stop future disclosures and sharing of information, but does not apply to past disclosures.*

Please make sure you fill in the entire form. Failure to fill in all of the information, as described above, will result in an invalid authorization and the Agency will be unable to fulfill your request.

Please contact the Records Department at (802) 728-4466 if you have any questions or need assistance in completing this form.

Send the completed authorization to:

CMC	CMC	CVSAS	WILDER	RAP
P.O. Box G	P.O. Box 278	P.O. Box 1468	P.O. Box 816	P.O. Box 760
11 Main Street	1483 Lower Plain	100 Hospitality Drive	39 Fogg Farm Rd	Norwich Avenue
Randolph, VT 05060	Bradford, VT 05033	Montpelier, VT 05601	Wilder, VT 05088	Wilder, VT 05088
Tele: (802) 728-4466	Tele: (802) 222-4477	Tele: (802) 223-4156	Tele: (802) 295-1311	Tele: (802) 295-8628
FAX: (802) 728-4197	FAX: (802) 222-3242	FAX: (802) 223-4332	FAX: (802) 295 1312	FAX: (802) 295-8638

CVAM
300 Granger Rd
Berlin, VT 05602
Tele : (802) 223-2003

Client # _____

FAX : (802) 223-2235