Po Box 1075 Montpelier VT 05601 - Phone: 802.252.2579 - Fax: 855.494.1575

Authorization to Release Information

I, ____(*name*)________________(*DOB*), authorize ____ to release my private clinical information to ____ for the purpose of ____.

Information to be Disclosed:

________Entire Record
________Drug and Alcohol Treatment Information
________Mental Health Treatment Information
________Other:______________________________
________Attendance
________Treatment Progress
________Recommendations
________Assessments

Method of Disclosure: Oral Written Electronic

Reciprocal Release: Yes No

Authorization & Signature

I authorize the release of my confidential protected health information, as described in my directions above. Further disclosure by the recipient is prohibited without specific consent, however, we make no guarantees regarding the practices of third parties.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, except to the extent that it has already been acted upon. Unless otherwise specified, this release expires one year after the termination of treatment. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

____ Date ____________________
Signature of Individual

____ ____________________
Signature of Parent/Guardian (if needed) Date

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information