VERMONT CENTER FOR RESILIENCY

Clinician's Name
Clinician's Degree and License
Vermont Center for Resiliency, PLLC
Office address
Burlington, VT 05401
Tel. 802-xxx-xxxx

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize _____ to: ____ Release to: ____ Obtain from:
(Name of Provider)

_____
(Name & Address of Person or Agency) *(Telephone #)*

Dates of Treatment From: _____ to _____

____ My Mental Health/Health Record in its ENTIRETY,
OR, Only the following information:
- ____ Medications
- ____ Treatment Recommendations
- ____ Progress Notes
- ____ Diagnosis/Assessment
- ____ Other: _____
  _____

____ My Substance Abuse Record in its ENTIRETY,
OR, Only the following information:
- ____ Medications
- ____ Treatment Recommendations
- ____ Progress Notes
- ____ Diagnosis/Assessment

____ Other:

This authorization will expire one year from the date signed below, unless revoked sooner in writing, **OR** upon the date, event, or condition noted here:
_____

The information will be used and disclosed for the following purpose(s):
____ Treatment Planning____ Continuity of Care ____ Diagnosis & Assessment ____ Other (explain below):
_____

I understand that I may revoke this authorization at any time by notifying the provider in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by my provider before receiving my revocation. I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. If the records are so protected, Federal Regulation (42 FR Par 2, Confidentiality of Alcohol and Drug Abuse Treatment Records) prohibit any further disclosure by the designated recipient of this information unless expressly permitted by the ***written consent*** *of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.* ***I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above.***

_____
Signature of Client Printed Name Date

_____
Signature of Representative (if applicable) Printed Name & Relationship to Client Date