NETWORKS inc.

149 Cherry Street, Burlington, VT 05401
Ph-802-863-2495, Fax-802-865-0534

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ , on behalf of _____ ,
(client or authorized representative, i.e. parent, guardian…) (write client's name or "self")

hereby authorize _____
(name of provider)

to receive or release the following indicated pertinent & relevant information;

To/From: _____
(Name of program/agency or provider)

_____
(Address) (phone #) (fax #)

_____ My Mental Health Treatment Record in its Entirety,
_____ My Substance Abuse Treatment Record in its Entirety,
_____ My Medical Record in its Entirety,
_____ My School Records

Or only the following information: (Please CHECK each line as applicable below)

___ Attendance records only
___ Intake summary/assessment
___ Diagnostic summary
___ Treatment Plan(s)
___ Medications
___ Course/summary of treatment
___ Drug & Alcohol toxicology screens
___ Evaluations (substance abuse, mental health, psychological, school)
___ Other: _____

The purpose of the disclosure authorized by this consent is: _____

I understand that (if applicable) behavioral health records and alcohol / drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 & 164 and cannot be disclosed or further re-disclosed by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or unless otherwise provided for in the regulations.

I understand that I may revoke this authorization/consent at any time by notifying the provider in writing, except to the extent that action has been taken in reliance on it. Thus, I understand that my revocation will not affect any actions taken by my provider before receiving my written revocation.

This consent/authorization shall be valid until client is discharged from treatment, **or** unless sooner revoked in writing, **or** upon the *date*, *event*, or *condition* noted here: _____

I have not been coerced to sign this authorization. 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 nor will I be denied services if I refuse to consent to a disclosure for other purposes. I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written or electronic.

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. I have read this release and understand its contents.

_____ _____ _____ _____
Signature of Client Print Name of Client DOB Date of Signature

Print Name of Personal Representative or person signing for client: _____

Relationship to client (parent, guardian, etc.)/Authority to sign: _____

Signature of Personal Representative: _____ Date: _____