UNITED COUNSELING SERVICE
UCS
BUILDING A STRONGER COMMUNITY

Authorization to Disclose Protected Health Information

I, _____ born on this date _____
Name of person whose information is being disclosed

authorize United Counseling Service of Bennington County to disclose the information as described below to

_____
Name of person/organization

_____
Address Phone

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

☐ All of my protected health information that includes mental health, substance use disorder, developmental, HIV/AIDS, dental and medical		
Or one or more of the following categories (check each of those authorized):		
☐ Mental health	☐ Substance Use Disorder	☐ Developmental
☐ HIV/AIDS	☐ Dental	☐ Medical

Type of Information/Record: Check the Information/Record type you wish disclosed.

☐Yes ☐No **<u>Entire Record</u>** - includes, but not limited to, assessments, treatment plans/support agreements, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.	
Or only those specified below (Please check Yes or No for each type):	
☐ Yes ☐ No	Assessments / Evaluations including diagnosis, treatment recommendations and associated test results
☐ Yes ☐ No	Treatment Plans / Support Agreements
☐ Yes ☐ No	Progress Reports/Notes on Treatment/ Support including associated test results
☐ Yes ☐ No	Medications Prescribed
☐ Yes ☐ No	Attendance
☐ Yes ☐ No	Behavioral Support Plans
☐ Yes ☐ No	Discharge Summary/Plan
☐ Yes ☐ No	Test Results
☐ Yes ☐ No	HIV/AIDS
☐ Yes ☐ No	Other (must specify):

Other specifics related to information/record to be disclosed (e.g. time period, specific progress notes):

_____

The means of this disclosure may be written, verbal or electronic.

The purpose of the disclosure: _____

Patient's name:_____ Patient's DOB: _____

I understand I may revoke my authorization at any time by informing United Counseling Service, but revocation will not affect any action already taken in reliance on it. If not previously revoked, this authorization will expire on the following date, event, or condition: _____
If none is indicated, this authorization will expire one year from the date it was signed below. In general, revocation should be submitted in writing and sent to the UCS Privacy Officer at 100 Ledge Hill Drive, Bennington, VT, 05201.

- I understand that my substance use disorder treatment records are protected under federal regulations, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise allowed by the regulations or required by law.
- I understand that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization. For disclosures of information made to organizations outside of the State of Vermont, health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996.
- I understand that the confidentiality of such records is also protected by State law.
- I understand that generally United Counseling Service may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.
- I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or healthcare operations.
- I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.
- I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment and healthcare operations and that United Counseling Service may or may not agree to the requested restrictions.

I have read all the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

_____ _____
Name of Patient (please print) Date

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Witness: Name and Title Date

Verbal revocation received: _____ (date) at _____ (time)

Staff Member: _____

Written revocation: I hereby revoke this authorization on _____ (date). Do not release any further information under this authorization.

Client/Guardian Signature: