Vermont Department of Corrections (DOC)
Authorization to Disclose Confidential Health Information

I, ____ *(print name)* Date of Birth: _____________ or my authorized representative ____ *(print name)* authorize the following individual or entity **to disclose and receive confidential health information**:

Department of Corrections:

VT Dept, of Corrections
____
(*name & address of DOC personnel authorized to disclose and receive confidential health information.*)

Provider, Other Entity, or Individual:

____
(*name & address of individual /health care providers, or general designation of other entities, or other individuals authorized to disclose confidential health information to and receive confidential health information from DOC*)

Type of Health Information

{Confidential health information includes personally identifying information and medical records, including mental health and substance use disorder records.}

Check to **RELEASE** each type of information for both Medical and Drug/Alcohol records, so only the appropriate information is released. You may check Entire Medical Record for medical records but must check specific record types for Drug/Alcohol information. If **RELEASE** is not checked, those records will not be released.

	MEDICAL	**DRUG/ALCOHOL**
Entire Medical Record[1]	☑ Release	
Diagnosis / Presenting Problem	☑ Release	☐ Release
Assessment Summaries / Evaluations	☑ Release	☐ Release
Treatment Recommendations	☑ Release	☐ Release
Treatment Plan / Support Agreement	☑ Release	☐ Release
Progress Report on Treatment / Support	☑ Release	☐ Release
Discharge Summary / Plan	☑ Release	☐ Release
Medication Prescribed	☑ Release	☐ Release
Mental Health Records	☑ Release	
HIV/AIDS Information	☑ Release	
Test Results (specify):	☑ Release	☐ Release

____

Other (be specific):	☐ Release	☐ Release

____

The purpose of this disclosure

COVID-19 or at the request of the individual
____
(Be as specific as possible, or at a minimum write "At the request of the individual.")

A general authorization for the release of medical or other confidential health information is NOT enough to authorize the release of drug and alcohol treatment records.

____ ____________________

Printed Name Date of Birth (DOB)

I have read and understand the reason(s) I am being asked to release information and the following:

- I do not have to authorize the release of this information. Signing this authorization is voluntary. If I choose not to sign, my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. By not giving authorization, I understand that I may not be able to fully participate in the programs and services stated in the purpose of this consent.
- <u>My drug and alcohol treatment records</u>: Are protected by federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written authorization or as allowed by the regulation.
  - If I listed a general designation entity and did not specify an individual provider on page 1, I may request in writing that DOC provide an accounting of the disclosures made pursuant to this authorization.
  - The federal rules restrict any use of drug and alcohol treatment information to criminally investigate or prosecute any drug or alcohol abuse patient.
  - Drug and alcohol treatment information may not be re-disclosed without my consent. Other types of confidential health information used and disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under state or federal law.
- I will be provided a copy of this form.
- I have the right to revoke this authorization at any time. I may revoke this authorization by verbally notifying my case worker or by contacting the DOC Health Services Division at the contact information listed below. I understand that I may revoke this authorization except to the extent that action has been taken in reliance on it.

Vermont Department of Corrections
Health Services Division
NOB 2 South, 280 State Drive
Waterbury, VT 05671-2000
Phone: 802-241-0025 Fax 802-241-0020

<u>Check Option A or Option B:</u>

Option A: ☐ Unless I revoke my consent earlier, I understand that this authorization will be in effect until I am no longer in physical custody or under community supervision of the Vermont Department of Corrections.

OR

Option B: ☐ I am **not** currently in physical custody or under community supervision of the Vermont Department of Corrections and I understand that, unless I revoke my consent earlier, this authorization will be in effect [check and complete one option]: ☐ One year from (*insert start date*): _______, **or** ☐ Until (*insert expiration date*): ________.

Signature of Individual or Authorized Representative: ________________________ **Date:** ___________
Describe authority of Authorized Representative (if applicable): ____

DOC Staff Name: __________________________ **Job Title**: _________________________________ **Date**: _________

An **<u>incomplete form</u>** will result in a defective authorization. The DOC will not disclose confidential health information with a defective authorization. Please make sure the **<u>entire</u>** form has been completed.

Alcohol/drug treatment related information released through this form must be accompanied by the following required statement: *42 CFR part 2 prohibits unauthorized disclosure of these records.*

To be completed by authorized DOC personnel only. Submit completed revocation to DOC Health Services Division:

Date Revoked: ______________________ DOC Staff Signature:______________________________________