# 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 individuals or entities **to disclose and receive confidential health information**:

Department of Corrections:

_____

(*name & address of DOC personnel authorized to disclose and receive confidential health information.*)

Provider, Other Entity, or Individual:

_____

_____

(*name & address of all 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. Add additional pages if necessary.*)

***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 is:**

_____

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

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

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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.
- My drug and alcohol treatment records 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

Unless I revoke my consent earlier, I understand that this authorization will be in effect for (**check just one** option below):

☐ One year from (*insert start date*): _____ or

☐ Until (*insert expiration date*): _____, or

☐ Until I am no longer receiving services from the Vermont Department of Corrections [**Only check this box if you are currently in DOC custody**].

**Signature of Individual or Authorized Representative:** _____

**Date:** _____

Describe authority of Authorized Representative: _____

An **incomplete form** will result in a defective authorization. The DOC will not disclose confidential health information with a defective authorization. Please make sure the **entire** 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: _____