Pathways Vermont
ending homelessness
rethinking mental health

1 Kennedy Drive, L2
South Burlington, VT 05403
(888) 492-8218

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____, authorize Pathways Vermont to:
(client name)

 Disclose information to Receive information from

Name of Agency or Individual: _____

Phone # _____ Fax # _____

Address: _____

The following information: *(Check Yes or No for each category; you may check Yes for the Entire Record)*

[ ] Yes	[ ] No	**Entire Record**
OR		*If you do not check entire record you must check yes or no in each category below*
[ ] Yes	[ ] No	Diagnosis, History, and Service Recommendations (Assessment/Evaluations)
[ ] Yes	[ ] No	Services Goals and Objectives (Service Plan)
[ ] Yes	[ ] No	Medical Information/Lab Results (to include substance abuse screenings)
[ ] Yes	[ ] No	Doctor's notes including medication information (Psychiatric Notes)
[ ] Yes	[ ] No	Progress Related to services-excluding Doctor's Notes
[ ] Yes	[ ] No	On-Call Contacts (On-Call Notes)
[ ] Yes	[ ] No	Attendance and Appointments
[ ] Yes	[ ] No	Discharge Information (Discharge Summary/Plan)

Information from:_____ (date) to _____ (date) *or* [ ] Entire Pathways Vermont Service Course

The purpose of this disclosure is:

 Service Coordination Personal Records Insurance Attorney Provider Transfer Disability Other: _____

Expiration: date or event upon which this authorization will expire: _____

I understand if I do not note a date or event, then this authorization will expire one year from the date it was signed below.

- By signing this form, you authorize Pathways Vermont and its agents to release information to or receive information from the parties listed on this document.
- All sections of this form must be completed. If any section of this form is incomplete, this form may be invalid.
- You must sign and date the form. If you are incapable of signing, a legally authorized representative (Health Care Agent or Legal Guardian) must sign and date the form AND attach supporting documentation.

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- If client is deceased, the "next of kin" or executor must sign and date the form AND attach supporting documentation.

I understand that:

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing, behavioral or mental health services, & treatment of alcohol or drug abuse.
- I understand that federal regulations (42 CFR part 2) prohibit the re-disclosure of drug and alcohol services information without my written consent or as allowed by the regulations. I understand that under Vermont statutes, my health information can only be disclosed with my authorization or as mandated by an express provision of law. 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 have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing addressed to: Pathways Vermont, 1 Kennedy Drive, L2 South Burlington, VT 05403
- My revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law.
- A fee may apply.
- Signing this form is voluntary, but I understand that I might be denied services if I refuse to consent to a disclosure for purpose of services, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

_____ _____ _____

(Signature of client or representative) (Date) (Date of birth)

_____ _____

(Print name of client or representative) (Relationship - if signed by representative)

Client Address: _____

City: _____ State: _____ Zip Code: _____ Phone # _____

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

Signature: _____ Date: _____

Last Updated: 1/12/24