Donnamarie (Dani) Carey, MS, LADC, LCMHC
Licensed Clinical Mental Health Counselor
Licensed Alcohol and Drug Counselor

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Authorization to Disclose Protected Health Information
_____Check and Highlight Here if Authorization Revoked

(For uses and disclosures not covered under treatment, payment, or healthcare operations, and for all Releases of Substance Abuse Information)

_____ , born on this date: _____/____/_____
(Name of person whose information is being requested)

Authorize the offices of: Donnamarie Carey to disclose to: Name/Agency: _____

Location: _____ Phone/Fax No.: _____

the following information (**Place and "X" in the box for each type of information for which you are authorizing disclosure**):

☐ Attendance	☐ Diagnosis/Presenting Problem	☐ Assessment Summaries/Evaluations
☐ Treatment Recommendations	☐ Medication Prescribed	☐ Aids/HIV Diagnosis or Treatment
☐ Treatment Plan/Support	☐ Behavioral Support Plans	☐ Progress Report-Treatment/Support
☐ Test Results	☐ Discharge Summary/Plan	☐ Entire Record
☐ Drug and Alcohol Information	☐ Other (specify):_____	

I agree to have information exchanged between both parties reciprocally: ☐ Yes ☐ No

Means of Disclosure (check all that are authorized): ☐ Written ☐ Oral ☐ Fax ☐ Electronic ☐ Video ☐ Audio ☐ Tape

The purpose of this disclosure is _____ This authorization is effective until _____

I understand that federal substance abuse privacy regulations (42 CFR part 2) prohibit the redisclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations. I understand that under Vermont statute, 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 the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by this rule (Privacy Standards of the Health Insurance Portability and Accountability Act of 1996).

I understand that my treatment/support is not conditioned upon authorizing this disclosure. I have received a copy of the provider's Notice of Privacy Practices (NPP). I understand I may revoke this authorization at any time except to the extent that the provider, or other entity making the disclosure, has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the provider at: Donnamarie Carey, POB 391, Montpelier, VT 05601.

_____ _____
Client Signature Date Clinician Date

_____
Parent /Guardian Signature Date

I hereby revoke this authorization on _____/_____/_____ at _____ AM PM. Do not release any further information under this authorization.

Signature: _____