



## Authorization For Release of Behavioral Health Records

NAME (print): \_\_\_\_\_ DOB: \_\_\_\_\_

FORMER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_

**SPECIFY INFORMATION TO BE RELEASED:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Psychiatric Evaluations       | <input type="checkbox"/> School Disciplinary Reports                        | <input type="checkbox"/> Attendance Records                       |
| <input type="checkbox"/> Psychological Evaluations     | <input type="checkbox"/> Adaptive Evaluations                               | <input type="checkbox"/> Other (Please specify)                   |
| <input type="checkbox"/> Treatment Plans               | <input type="checkbox"/> Educational Reports (i.e. IEP, ER)                 | <input type="checkbox"/> <b>Complete Behavioral Health Record</b> |
| <input type="checkbox"/> Diagnosis                     | <input type="checkbox"/> Behavioral Management Plans (Disciplinary Reports) | Date Range: ___/___/___ to ___/___/___                            |
| <input type="checkbox"/> Neurological                  | <input type="checkbox"/> Transfer/Discharge Summaries                       |   |
| <input type="checkbox"/> Psychological Testing Reports |   |   |

**FORM OF DISCLOSURE:**  Written  Verbal

**METHOD OF DELIVERY:**  U.S. Mail  Fax (health providers only; not to exceed 50 pages)  CD

Pick up in person at Medical Records Department

**FEES: If paper records are released to the patient fee is \$0.50 per page or \$5 minimum; a CD is \$10 (18 V.S.A. §9419)**

**Information REQUESTED FROM:**

DOCTOR/FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE/FAX: \_\_\_\_\_

**SPECIFIC PURPOSE OF TOPICS CHECKED:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Coordination of Educational Services | <input type="checkbox"/> Coordination of Treatment/Services | <input type="checkbox"/> External Agency/Provider |
| <input type="checkbox"/> Referral to External Agency/Provider | <input type="checkbox"/> Insurance/Social Security Benefits | <input type="checkbox"/> Other _____              |

**Information RELEASED TO:**

AGENCY/ENTITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE/FAX: \_\_\_\_\_

I request the above information be released. I understand that information released in my medical record may include information on drug and alcohol abuse, psychiatric impairments, AIDS/HIV related illnesses or genetic testing. I understand that I have the right to restrict this information should I choose. I understand that federal regulations (42 CFR part 2) prohibit the re-disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations. I understand that under VT statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures made to organizations outside of the State of VT, all other health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

I understand this authorization is voluntary and can be revoked in writing at any time. A revocation must be submitted in writing to the address above. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released.

Authorization to release this information is valid for 12 months from the date of signature on this release. A photocopy or facsimile of this authorization is as valid as the original.

NOTE: Once information has been disclosed, can no longer protect it from Community Health further disclosure.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient, or if minor, as applicable,  
Parent/Guardian/Loco Parentis

\_\_\_\_\_  
Date