UNITED COUNSELING SERVICE
UCS
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Authorization to Disclose Protected Health Information

Authorization is generally required in situations where the intended disclosure of your health information is for purposes that are *not* related to your treatment, payment for your care, and healthcare operations. If you need UCS to disclose your health information to more than one person/organization, an additional Authorization is required.

I, _____ born on this date _____
Printed name of client

authorize United Counseling Service of Bennington County to disclose the information as described below to

_____
Name of person/organization

_____
Address Phone

Category of Protected Health Information
I authorize the following category(s) of health information to be disclosed:

☐ All my protected health information that includes mental health, substance use disorder, developmental, HIV/AIDS, dental, and medical

Or

☐ Mental health
☐ Developmental
☐ Substance Use Disorder
☐ Medical
☐ HIV/AIDS
☐ Dental

Type of Information/Record
I authorize the following records to be disclose:

☐ Entire Record that includes, but not limited to, assessments, treatment plans/support agreements, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.

Or

☐ Assessments, evaluations, and screeners including diagnosis, treatment recommendations and associated test or screening results
☐ Plans including treatment plans, behavior support plans, crisis plans, and discharge plans/summaries
☐ Progress notes including progress towards goals, service delivered, start and end times, service date, treatment recommendations, and test results
☐ Diagnosis
☐ Allergies
☐ Vital signs
☐ Medications prescribed
☐ Test Results
☐ HIV/AIDS
☐ Attendance and for all scheduled appointments
☐ Other not listed or specific details such as time frame, specific notes, etc.:

Please know that the means of this disclosure may be written, verbal or electronic.

Purpose of Disclosure
☐ Legal representation
☐ Behavior support in school
☐ Coordination with probation officer
☐ Disclosure to potential home/respite provider
Other:

Is this Authorization to keep on file or do you need UCS to disclose your records?
☐ Keep on file ☐ Disclose records ☐ Both

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Patient's name:_____ Patient's DOB: _____

I understand I may revoke my authorization at any time by informing United Counseling Service, but revocation will not affect any action already taken in reliance on it. In general, revocation should be submitted in writing and sent to the UCS Privacy Officer at 100 Ledge Hill Drive, Bennington, VT, 05201.
If not previously revoked, this authorization will expire on the following date, event, or condition _____.
If none is indicated, this authorization will expire one year from the date it was signed below.

- I understand that my substance use disorder treatment records are protected under federal regulations, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise allowed by the regulations or required by law.
- I understand that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization. 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 understand that the confidentiality of such records is also protected by State law.
- I understand that generally United Counseling Service may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.
- I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or healthcare operations.
- I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.
- I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment and healthcare operations and that United Counseling Service may or may not agree to the requested restrictions.

I have read all the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

_____ _____
Printed name of client, parent, or legal guardian Date

_____ _____
Signature of client, parent, or legal guardian Date

_____ _____
Printed name of staff person who assisted Date

FOR REVOCATIONS ONLY

Verbal revocation received: _____ (date) at _____ (time)

Staff Member: _____

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

Client/Guardian Signature: