Paula Shulman, LICSW – CASAC – LADC

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Authorization for Exchange of Information

Name of Individual Receiving Services ______________________Date of Birth _______

I hereby authorize ____

To disclose and receive from ____

Address/phone: ____

For the Purpose of ____

Exchange includes: via telephone, email, phone and in person.

Extent of Nature of Information to be disclosed:
__________ Any Information Pertinent to Treatment
__________ Office Notes
__________ Laboratory Tests
__________ Psychological Testing
__________ Progress Notes
__________ Treatment Goals and Recommendations
__________ Discharge/Summary
__________ Medications
__________ Diagnosis /presenting problem
__________ Information from other providers
__________ Other

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, (42 CFR part 2) and the Health Insurance Portability and Accountability Act of 1996, 45 CFR Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in 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 of 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 understand I may revoke this authorization at any time except to the extent that Paula Shulman, or other agency making this disclosure, has already acted in reliance on it. In general, revocation should be submitted in writing and forwarded to Paula Shulman.

Consent for Release is effective as of: ____

Consent for Release expires on: ____

Signature of Patient _____________________________________ Date____________