The purpose of the disclosure: ____

____

I understand I may revoke my authorization at any time by informing Howard Center, but revocation will not affect any action already taken in reliance on it. 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. In general, revocation should be submitted in writing and sent to Howard Center, Health Information, 300 Flynn Ave, Burlington, VT 05401

- 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 Howard Center 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 Howard Center may or may not agree to the requested restrictions.

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

____
Name of Patient (please print)

______________________________ ______________________
Signature of Patient or Parent/Guardian Date

______________________________ ______________________
Witness Signature: Name and Title Date

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: