Vermont Communication Support Project

Authorization for Release of Information

I, _____, hereby give my permission for

_____ (name of agency and/or professional) to provide information and records, including protected health information (PHI)*, about me and my disability-related history, needs, treatments, behaviors, and potential accommodations to the Vermont Communication Support Project (VCSP), and to any VCSP Communication Support Specialist assigned to my case. I give my authorization for my PHI, which may include mental health records, substance abuse treatment records, and related case files held by the above named agency and/or provider, to be released to and/or discussed with the VCSP director and Communication Support Specialist assigned to my case. I understand that this release is intended to be used so that the VCSP and a Communication Support Specialist may obtain information from the individual or agency listed above to assist me in participating in the judicial and/or administrative process in which I am currently involved. I understand that I may revoke this Authorization at any time by indicating to the VCSP verbally or in writing that I wish to revoke it. If I do not revoke this Authorization, it will be valid for one year from the date of my signature.

Signed (client):_____ Date: _____

Print Name: _____

Address:

Telephone:

E-mail:

Contact Information for Provider

Name:

Address:

Telephone:

E-mail:

*Protected health information (PHI) is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that is identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.

Please e-mail this form to: csp@disabilityrightsvt.org OR Fax to: 802-229-1359 Attn: VCSP Director