OPIATE CARE ALLIANCE of CHITTENDEN COUNTY

CONSENT TO DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND COORDINATION OF CARE

I, _____, date of birth _____, authorize the use and disclosure of my personal health information by and among each of the members of the Opiate Care Alliance of Chittenden County ("OCACC") including the staff of each member organization. The following organizations are members of the OCACC:

- Community Health Centers of Burlington, Inc.;
- Howard Center, Inc.;
- University of Vermont Medical Center, Inc.;
- Maple Leaf Farm Associates, Inc.; and
- Vermont Department of Health's Alcohol and Drug Abuse Programs.

THE MEANS OF THIS DISCLOSURE MAY BE WRITTEN, VERBAL, OR ELECTRONIC.

I understand that the purposes for the use and disclosure of my personal health information among the staff of the organizations that make up the OCACC are as follows: screening, assessment, placement, treatment planning, referral for treatment, monitoring progress, coordination of care, and aftercare.

The personal health information to be shared among the members of the OCACC will include the following:

(1) Name and other identifying information (including living situation and social history);
(2) Medical assessment, diagnosis, treatment, progress in treatment, and discharge summary;
(3) History and participation in services; and
(4) Mental health and/or drug and alcohol screening, urine drug screen results, assessment, diagnosis, treatment, progress, and discharge summary.

ADDITIONAL PROVISIONS CONCERNING YOUR CONSENT:

I understand that my decision to use the services offered by the OCACC is voluntary, and I may end services with members of the OCACC at any time.

I also may revoke this Consent at any time by notifying any member of the OCACC, but revoking this Consent will not affect any actions which were taken by the OCACC or its member organizations before I revoked the Consent. If not previously revoked, this Consent will terminate on the following date, event, or condition: _____. If none is indicated, this consent will remain in effect until one year after the last day of services provided to me by a member of the OCACC.

I understand that information used by and disclosed to members of the OCACC include medical, mental health, and/or substance abuse treatment information. I understand that regulations regarding federally assisted drug and alcohol treatment programs, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, prohibit the re-disclosure of this type of information without

my written consent unless otherwise allowed by the regulations or required by law. I understand that the confidentiality of such records is also protected by State law.

I understand that if I want members of the OCACC to disclose personal health information about me to someone other than members of the OCACC, I will need to sign a separate consent or authorization form. I understand that generally the members of OCACC may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied participation in the OCACC if I do not sign a consent 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 consent to a disclosure for other purposes.

I understand that I may request restrictions on the use or disclosure of information for the purposes described in this Consent and that any of the members of OCACC may or may not agree to the requested restrictions.

I have read all the above information, and I understand its contents and consent to the use and disclosure of the personal health information identified above to members of the OCACC.

_____ _____

Name of Patient (please print) Date

_____ _____

Signature of Patient or Parent/Guardian Date

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

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

Signature: _____

PCP Name: _____

Insurance Plan: _____