Blue Spruce Health, PLLC, Authorization to Request or Disclose Health Information

I, _____ born on this date _____ authorize
(Name of person whose information is being disclosed) *(MM/DD/YYYY)*

BLUE SPRUCE HEALTH, PLLC. to ☐ disclose to / ☑ obtain from *(check one or both)* Name of person or organization:_____

Mailing address: _____ Phone: _____ Fax: _____
information as described below.

Authorization is for: ***Check all that apply***

☐ Verbal Communication
☑ Disclose/Obtain Health Records

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

☑ All of my protected health information that includes mental health, substance use disorder, developmental, HIV/AIDS, dental and medical			
Or one or more of the following categories (check each of those authorized):			
☐ Mental health	☐ Substance Use Disorder	☐ Developmental	☐ Other - Please specify:
☐ HIV/AIDS	☐ Dental	☐ Medical	

Type and Time Period of Information/Record: Enter the Time Period and check the Information/Record type of records you wish disclosed.
Information/Records to be disclosed will cover the time period from _____ to _____
(MM/DD/YYYY) *(MM/DD/YYYY)*

☑ **Entire Record** - includes, but not limited to, assessments, treatment plans/support agreements, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.	
Or only those specified below (Please check Yes or No for each type):	
☐ Yes ☐ No	Assessments / Evaluations including diagnosis, treatment recommendations, associated screening test results and/or Safety Plans
☐ Yes ☐ No	Treatment Plans
☐ Yes ☐ No	Progress Reports/Notes on Treatment/Emergency Notes
☐ Yes ☐ No	Medications Prescribed
☐ Yes ☐ No	Attendance

☐ Yes ☐ No	Behavioral Support Plans
☐ Yes ☐ No	Discharge Summary/Plan
☐ Yes ☐ No	Lab Results
☐ Yes ☐ No	HIV/AIDS
☐ Yes ☐ No	Correspondence (including third party information)
☐ Yes ☐ No	Other (must specify):

***Purpose of Disclosure*:**

☐ Coordination of Care	☐ Legal	☐ Disability Determination
☐ Transfer of Care	☐ Personal	☐ Other: (*Please specify*)

I understand I may revoke my authorization at any time by informing Blue Spruce Health, PLLC (BSH) 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: Blue Spruce Health, PLLC, ATTN: Medical Records, 401 East Main Street, Newport, VT 05855.**

- I understand that any 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 BSH 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. For example, BSH may ask me to sign an authorization allowing disclosures to my landlord, if they are helping facilitate that relationship in some manner.
- If I refuse, they may not be able to provide such services. 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 BSH 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) Date

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness: Name and Title Date

SEND records to: Blue Spruce Health
Fax: 802-866-1394 Phone: 802-327-7079 Email:info@bluespruce.care