VALLEY VIEW AT COTTAGE STREET, LLC

AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION

<u>Authorization for Use/Disclosure of Information</u>: I voluntarily consent to authorize my health care provider(s) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

<u>Recipient</u>: I authorize my health care information to be released to the following recipient(s):

Valley View at Cottage Street, LLC	Fax: (802)-333-7091
92 Cottage Street	Office: (802)-333-4829
Bradford, Vermont 05033	Email: admin@vvhome.org

<u>Purpose</u>: I authorize the release of my health information for the following specific purpose:
____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

<u>Information to be disclosed</u>: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in their possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ❑ Only the following records or types of health information:
  ____.

<u>Term</u>: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until ____________.
- ❑ Until the provider fulfills this request.
- ❑ Until the following event occurs:_____________________________________
- ❑ This Authorization may remain in effect until the provider is otherwise notified in writing.

<u>Redisclosure</u>: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

<u>Refusal to sign/right to revoke</u>: I understand that signing this form is voluntary and that I have the right to revoke this authorization at any time. If I change my mind, I understand that I am required to provide a written notice of revocation to both the authorized provider releasing my health information and the Administrator of Valley View. The revocation will be effective immediately upon receipt of written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

<u>Questions:</u> I may contact the Administrator at Valley View by calling (802)-333-4829 or by email at admin@vvhome.org.

______________________________________ ___________________ _________________________
Patient Name DOB Date Signature

If an individual is unable to sign this Authorization for any reason(s), please complete the information below:

_________________________ _________________________ _____________ _____________
Name of Guardian/ Representative Legal Relationship Date Witness

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[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**