Lamoille County Mental Health Services
Authorization to Disclose Health Information

I, Leila Flanagan born on this date 6/4/2009
(Name of person whose information is being requested)

authorize Lamoille County Mental Health
(Name & address of person/agency making the disclosure)

to disclose to Richmond Pediatrics
(Name & address of person/agency receiving the disclosure)

the following information (select box for type of information being requested):

	Information Type		Information Type		Information Type
☐	Attendance	☐	Diagnosis / Presenting Problem	☐	Assessment Summaries / Evaluations
☐	Treatment Recommendations	☐	Medication Prescribed	☐	AIDS/HIV Diagnosis or Treatment Information
☐	Treatment Plan / Support Agreement	☐	Behavioral Support Plans	☐	Progress Report on Treatment/ Support
☐	Test Results	☐	Discharge Summary/Plan	☑	Entire Record
☐	Drug and Alcohol Information	☐	Other (Specify):	☐	Other (Specify):

Time period or other specifics related to the information to be disclosed: _____

The purpose of this disclosure is: mental health care

Means of Disclosure (check all that apply): ☑ Written ☑ Oral ☑ Electronic ☑ Video ☑ Audio Tape

I understand that federal regulations (42 CFR part 2) prohibit the redisclosure of drug & alcohol treatment information without my written consent or as allowed by the regulations. I understand that under Vermont statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by this rule (Privacy Standards of the Health Insurance Portability and Accountability Act of 1996).

I understand that my treatment/support is not conditioned upon authorizing this disclosure. I understand I may revoke this authorization at any time except to the extent that the Agency, or other agency making the disclosure, has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the Agency at the address below.

Date or event upon which this authorization will expire: 4/4/24. I understand if I do not note a date or event, then this authorization will expire one year from the date it was signed below.

Client's Signature: _____ Date: _____

Parent/Guardian
Or Legal Representative's Signature: Nancy Dumont Date: 4/4/23

Witness' Signature: _____ Date: _____

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

Signature:

See back for instructions

LCMHS is committed to and responsible for protecting the privacy of your health information. The information we ask from you on the front of this form will help us to fulfill this responsibility.

Name of person whose information is being requested: This is the name of the person that LCMHS has provided services to and is maintaining information on. This should not be confused with the requestor or an individual's parent/guardian.

Birth Date: Along with your name we use your birthday as a means to identify you. On occasion we may request additional information such as your social security number. We do this because some names are common and birthdays and social security numbers can be used to identify the right person.

Name and address of person/agency making the disclosure: This is the organization or person you are asking to disclose information about you. In most cases this will be LCMHS but we could be requesting information from another provider. Be sure to include the address or we will not know where to send it.

Name and address of person/agency receiving the disclosure: We are asking to whom and to where do you want us to send the information. If LCMHS is requesting the information then our name and address will be listed here.

Information: What kind of information do you want released? Circle Y for yes for each information type you want us to disclose. Circle N for no for the information types you DO NOT want us to disclose. You need to answer Y or N for each information type so we can make sure we are only releasing the information you wish.

Purpose of this disclosure: By telling us why you want this information disclosed, we can ensure we only release the minimum amount of information necessary to meet the purpose of your release. If you don't want to tell us, you can write, "At the request of the individual" in this section.

Means of Disclosure: Health information is maintained in various formats and we need to know in what format you wish us to disclose it. At this time most of the health information we are maintaining on you is in written form.

Date or event upon which this authorization will expire: Tell us when we should no longer release information about you. In most cases that will be once we have sent the information requested to the party you wanted to receive it. This authorization will automatically expire a year from the date you signed it unless you tell us an event or other date when it should end.

Signatures: In order for LCMHS to honor your request the authorization form must by signed by you if you are an adult or an emancipated minor. If you are an adult but have a legal guardian or representative they must sign this form. If you are under 18 years of age your parent/guardian must sign for you. However, if you are a minor who is 12 years of age or older and sought confidential drug/alcohol treatment under a physician's care then only you can sign this form not your parents or guardians. LCMHS requires a copy of guardianship papers or documentation of legal representation in order to honor a release from a guardian or legal representative. All signatures must be dated. In order to protect your information we may ask you to provide identification to make sure you are you. The witness signature is not required but can helps us identify you if a member of our staff who knows you signs as the witness.

Revoking Authorization: If you decide to change your mind about disclosing this information in the future, you can take back your authorization. Call or stop in to complete this section. *This revocation can not be applied to information we disclosed with your permission and prior to your revocation.*

Failure to fill in all of the information (except for the signature of a child under 18 years of age) will result in a faulty authorization and the Agency will be unable to fulfill your request. Please make sure you fill in the entire form.

Please contact the Records Librarian at (802) 888-5026 if you have any questions or need assistance in completing this form.

Send the completed authorization to:

Lamoille County Mental Health Services
Records Librarian
72 Harrel Street
Morrisville, VT 05661
Or fax to (802) 888-6393

Lamoille County Mental Health Services
Authorization to Disclose Health Information

I, Leila Flanagan (Name of person whose information is being requested) born on this date 6/04/2009

authorize Richmond Pediatrics (Name & address of person/agency making the disclosure)

to disclose to Lamoille county mental health (Name & address of person/agency receiving the disclosure)

the following information (select box for type of information being requested):

	Information Type		Information Type		Information Type
☐	Attendance	☐	Diagnosis / Presenting Problem	☐	Assessment Summaries / Evaluations
☐	Treatment Recommendations	☐	Medication Prescribed	☐	AIDS/HIV Diagnosis or Treatment Information
☐	Treatment Plan / Support Agreement	☐	Behavioral Support Plans	☐	Progress Report on Treatment/ Support
☐	Test Results	☐	Discharge Summary/Plan	☑	Entire Record
☐	Drug and Alcohol Information	☐	Other (Specify):	☐	Other (Specify):

Time period or other specifics related to the information to be disclosed: _____

The purpose of this disclosure is: mental health care

Means of Disclosure (check all that apply): ☑ Written ☑ Oral ☑ Electronic ☑ Video ☑ Audio Tape

I understand that federal regulations (42 CFR part 2) prohibit the redisclosure of drug & alcohol treatment information without my written consent or as allowed by the regulations. I understand that under Vermont statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by this rule (Privacy Standards of the Health Insurance Portability and Accountability Act of 1996).

I understand that my treatment/support is not conditioned upon authorizing this disclosure. I understand I may revoke this authorization at any time except to the extent that the Agency, or other agency making the disclosure, has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the Agency at the address below.

Date or event upon which this authorization will expire: 4/4/24. I understand if I do not note a date or event, then this authorization will expire one year from the date it was signed below.

Client's Signature: _____ Date: _____

Parent/Guardian
Or Legal Representative's Signature: Nancy Gilman Date: 4/4/23

Witness' Signature: _____ Date: _____

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

Signature:

See back for instructions

LCMHS is committed to and responsible for protecting the privacy of your health information. The information we ask from you on the front of this form will help us to fulfill this responsibility.

Name of person whose information is being requested: This is the name of the person that LCMHS has provided services to and is maintaining information on. This should not be confused with the requestor or an individual's parent/guardian.

Birth Date: Along with your name we use your birthday as a means to identify you. On occasion we may request additional information such as your social security number. We do this because some names are common and birthdays and social security numbers can be used to identify the right person.

Name and address of person/agency making the disclosure: This is the organization or person you are asking to disclose information about you. In most cases this will be LCMHS but we could be requesting information from another provider. Be sure to include the address or we will not know where to send it.

Name and address of person/agency receiving the disclosure: We are asking to whom and to where do you want us to send the information. If LCMHS is requesting the information then our name and address will be listed here.

Information: What kind of information do you want released? Circle Y for yes for each information type you want us to disclose. Circle N for no for the information types you DO NOT want us to disclose. You need to answer Y or N for each information type so we can make sure we are only releasing the information you wish.

Purpose of this disclosure: By telling us why you want this information disclosed, we can ensure we only release the minimum amount of information necessary to meet the purpose of your release. If you don't want to tell us, you can write, "At the request of the individual" in this section.

Means of Disclosure: Health information is maintained in various formats and we need to know in what format you wish us to disclose it. At this time most of the health information we are maintaining on you is in written form.

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Signatures: In order for LCMHS to honor your request the authorization form must by signed by you if you are an adult or an emancipated minor. If you are an adult but have a legal guardian or representative they must sign this form. If you are under 18 years of age your parent/guardian must sign for you. However, if you are a minor who is 12 years of age or older and sought confidential drug/alcohol treatment under a physician's care then only you can sign this form not your parents or guardians. LCMHS requires a copy of guardianship papers or documentation of legal representation in order to honor a release from a guardian or legal representative. All signatures must be dated. In order to protect your information we may ask you to provide identification to make sure you are you. The witness signature is not required but can helps us identify you if a member of our staff who knows you signs as the witness.

Revoking Authorization: If you decide to change your mind about disclosing this information in the future, you can take back your authorization. Call or stop in to complete this section. *This revocation can not be applied to information we disclosed with your permission and prior to your revocation.*

Failure to fill in all of the information (except for the signature of a child under 18 years of age) will result in a faulty authorization and the Agency will be unable to fulfill your request. Please make sure you fill in the entire form.

Please contact the Records Librarian at (802) 888-5026 if you have any questions or need assistance in completing this form.

Send the completed authorization to:

Lamoille County Mental Health Services
Records Librarian
72 Harrel Street
Morrisville, VT 05661
Or fax to (802) 888-6393

Lamoille County Mental Health Services
Authorization to Disclose Health Information

I, Leila Flanagan born on this date 6/14/2009
(Name of person whose information is being requested)

authorize Vermont Gynecology
(Name & address of person/agency making the disclosure)

to disclose to Lamoille County Mental Health
(Name & address of person/agency receiving the disclosure)

the following information (select box for type of information being requested):

	Information Type		Information Type		Information Type
☐	Attendance	☑	Diagnosis / Presenting Problem	☑	Assessment Summaries / Evaluations
☐	Treatment Recommendations	☑	Medication Prescribed	☐	AIDS/HIV Diagnosis or Treatment Information
☐	Treatment Plan / Support Agreement	☐	Behavioral Support Plans	☐	Progress Report on Treatment/ Support
☐	Test Results	☐	Discharge Summary/Plan	☐	Entire Record
☐	Drug and Alcohol Information	☐	Other (Specify):	☐	Other (Specify):

Time period or other specifics related to the information to be disclosed: _____

The purpose of this disclosure is: mental health care

Means of Disclosure (check all that apply): ☑ Written ☑ Oral ☑ Electronic ☑ Video ☑ Audio Tape

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Date or event upon which this authorization will expire: 4/4/24. I understand if I do not note a date or event, then this authorization will expire one year from the date it was signed below.

Client's Signature: _____ Date: _____

Parent/Guardian
Or Legal Representative's Signature: Nancy J Dehart Date: 4/4/23

Witness' Signature: _____ Date: _____

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

Signature:

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Lamoille County Mental Health Services
Authorization to Disclose Health Information

I, Leila Flanagan (Name of person whose information is being requested) born on this date 6/4/2009

authorize Lamoille County Mental Health (Name & address of person/agency making the disclosure)

to disclose to Vermont Gynecology (Name & address of person/agency receiving the disclosure)

the following information (select box for type of information being requested):

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Client's Signature: _____ Date: _____

Parent/Guardian
Or Legal Representative's Signature: Nancy J. DuMont Date: 4/1/23

Witness' Signature: _____ Date: _____

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

Signature:

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