

**CHOICES FOR CARE
AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION**

NAME: _____
(Please Print) (Date of Birth)

I give my permission for the Department of Disabilities, Aging and Independent Living (DAIL) Long-Term Care Clinical Coordinator (LTCCC), the Department for Children and Families, my legal representative, the local Waiver team and all applicable Choices for Care program Providers to communicate with and disclose to one another information contained in my **Choices for Care** application and assessment.

In addition, I give permission for the LTCCC and the following individuals and/or agencies (check all that apply) to share and disclose my medical information to one another. My Medical information includes, but is not limited to, Medications, Diagnoses, Assessment and Treatment Plans, OT/PT/SLP or other Therapy information from the dates: _____ to _____. This information will facilitate **Choices for Care** eligibility determination, service coordination and program monitoring.

Family/Friend: _____

Hospital: _____

Physician: _____

Mental Health Agency: _____

Housing Provider: _____

Community Health Team: _____

VT Chronic Care Initiative Nurse: _____

Home Health Agency: _____

Area Agency on Aging: _____

Other(s): _____

(Please read Statement of Understanding below and sign)

Statement of Understanding

I understand:

- That all information concerning me will be respected as confidential by these entities and that it will be used solely to facilitate **Choices for Care** eligibility determination, service coordination and program monitoring.
- I do not have to agree to the release of this information, and if I choose not to, any benefits to which I am entitled will not be affected. However, if I decline to release information, it may affect my eligibility for the **Choices for Care** program.
- My drug and alcohol treatment records are protected by Federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.
- While DAIL takes every precaution to protect my other health information (not alcohol/drug), once it is released pursuant to this authorization it may be subject to re-disclosure by other parties.
- I may revoke this authorization at any time except to the extent that it has been acted upon. To revoke this authorization, I must contact the LTCCC below.
- If I do not revoke this authorization, it will be in effect as long as I am receiving Choices for Care services. I will be provided with a copy of this form.

DAIL LTCCC NAME

(DATE)

Signature of Individual or Legal Representative giving Authorization

(DATE)

BY CHECKING THIS BOX I DECLINE TO HAVE A COPY OF THIS AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION: