**Katie McLean Hoar, LCSW**
Firefly Counseling, LLC
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# Authorization to Disclose Health Information

I, _____ born on this date _____ authorize
(Name of person whose information is being requested)
Katie McLean Hoar, LCSW at Firefly Counseling, LLC to disclose the following information to

_____ :
(Name of person/ agency receiving the disclosure)

*(Please check each category for which you approve disclosure of information, and do not check any categories that you wish to remain confidential and not be included in disclosure)*

▢ Attendance
▢ Engagement (that the person listed above is participating in therapy)
▢ Treatment goals
▢ Treatment progress
▢ Behavior support plan(s) (if applicable)
▢ Treatment recommendations
▢ Discharge summary/ plan
▢ Other (Specify): _____

OR

▢ **Entire record** - includes, but is not limited to, all categories noted above and may include mental health, substance abuse, developmental, HIV/AIDS and/ or other medical information.

The purpose of this disclosure is:
▢ Treatment planning
▢ Assessment
▢ Care coordination
▢ Intervention
▢ Client request (please explain): _____
_____

I understand that federal regulations (42 CFR part 2) prohibit the redisclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations. I understand that under Vermont statutes, 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, 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 I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment or health care operations, if permitted by state law. I will not be denied services if I refuse consent to a disclosure for other purposes. I understand that I may revoke this authorization at any time except to the extent that Katie McLean Hoar, LCSW or other agency making the disclosure has already acted in reliance on it. In general, any revocation should be submitted in writing and sent to Katie McLean Hoar, LCSW at the address at the top of this form.

Expiration: This authorization to disclose is **valid for one year** unless otherwise specified with a date here _____.

Client signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Clinician signature: _____ Date: _____

If applicable: On _____ (date), I hereby revoke this authorization. Do not release any further information under this authorization.

Signature: _____