

**VERMONT DEPARTMENT OF HEALTH MEDICATION ASSISTANCE PROGRAM  
RELEASE OF INFORMATION**

I, \_\_\_\_\_, authorize the Vermont Department of Health  
(Print Name)

Medication Assistance Program staff to receive and disclose medical, dental, insurance, and eligibility information pertaining to my immune-compromised related condition to and from the service providers listed below. I understand that information will be disclosed only to determine eligibility for the Medication Assistance Program or to arrange for payments (insurance premiums, co-pays, deductibles and dental services), on my behalf for these programs. I also understand that information will be disclosed only on an as needed basis and only to the necessary providers and programs.

<p><input checked="" type="checkbox"/> <b>Department of Children &amp; Families - Economic Services Division</b></p> <p><input checked="" type="checkbox"/> <b>Medical facility Staff</b> (<i>Name of provider/office</i> _____)</p> <p><input checked="" type="checkbox"/> <b>Community Service Organization Staff</b> (<i>Name of organization</i> _____)</p> <p><input checked="" type="checkbox"/> <b>Dental Provider Staff</b> (<i>Name of provider/office</i> _____)</p> <p><input checked="" type="checkbox"/> <b>Pharmacy Staff</b> (<i>Name of Pharmacy</i> _____)</p> <p><input checked="" type="checkbox"/> <b>Med Metrics, COPS, PDP team, HP Staff</b> (<i>to assist with claims and eligibility issues</i>)</p> <p><input checked="" type="checkbox"/> <b>Insurance Company Staff</b> (<i>Name of company</i> _____)</p> <p><input type="checkbox"/> <b>Other</b> (<i>specify name and relationship to you</i> _____)</p>
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By signing this form, I understand:

- ✓ The reason(s) I am being asked to release information.
- ✓ I do not have to agree to the release of information. However, by not giving authorization, I will not be able to obtain all of the assistance I may need with my medication, insurance and dental needs.
- ✓ If I choose not to sign this form any benefits for which I am entitled to will not be affected.
- ✓ While the AHS takes every precaution to protect my health information once it is disclosed pursuant to this authorization, it may be subject to re-disclosure.
- ✓ If I am authorizing AHS to share information about immune-compromised treatment, the recipient may not share my information with others unless permitted to do so by law.
- ✓ I may revoke this authorization at any time by contacting the Medication Assistance Coordinator at 802-951-4005, except to the extent that it has been acted upon.
- ✓ If I do not revoke or update this authorization, it will be in effect as long as I am receiving Medication Assistance Program services.
- ✓ I will be provided a copy of this form.
- ✓ All items on this form and my questions about this form have been answered.

**Client's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please return this form to:

Medication Assistance Program Coordinator  
VT Dept of Health  
P.O. Box 70, Drawer 41 IDEPI  
Burlington, VT 05402  
(802)-951-4005 or 1-800-464-4343 ext 4005