

**VERMONT DEPARTMENT OF HEALTH AIDS PROGRAM
RELEASE OF INFORMATION**

I, _____, authorize the Vermont Department of Health
(Print Name)
HIV/AIDS Program staff to receive and disclose medical, dental, insurance, and eligibility information pertaining to my HIV-related condition to and from the service providers listed below. I understand that information will be disclosed only to determine eligibility for the HIV/AIDS Assistance Programs or to arrange for payments 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.

Department of Prevention, Assistance, Transition and Health (PATH, formerly DSW)

Physician and treating facility

AIDS Service Organization case manager (Name _____)

Dental Provider

Pharmacy

Social Worker (Name _____)

Vermont Dept. of Health AIDS Service Programs (Dental, Insurance, Medication)

Spouse/Domestic Partner/Partner in a Civil Union (Name _____)

Family member (Specify _____)

Other (specify _____)

Patient's Signature _____ **Date** _____

Please return this form with completed application(s) to

AMAP Coordinator
Vermont Department of Health
108 Cherry St., Drawer 41 HAST
P.O. Box 70
Burlington, VT 05402-0070
(802) 951-4005 or 1-800-464-4343 ext 4005