**Individual Career Advancement Network (ICAN)**
**Authorization to Release Information Obtained from a Healthcare, Mental Health and/or Substance Use Provider**

*This form must be physically signed or electronically signed with multifactor (two-step) authentication.*

**Participant information**

Participant name: _____
Last 4 of SSN: _____
Head of household name: _____
Head of household last 4 of SSN: _____
Phone/email contact information: _____
Name of legal representative (if applicable): _____

**About ICAN and this authorization**

The Individual Career Advancement Network (ICAN) is a multidisciplinary team that provides training, education, and support services to help participants overcome obstacles to employment and improve their earning capacity.

**Core ICAN Team - permission granted by signing**

By signing this form, I, or my legal representative, give permission to ALL members of the Core ICAN Team listed below to communicate with one another and share the information I authorize on this form for the purposes I authorize. I do not need to check individual Core ICAN Team members.

- Economic Services Division
- EAP (Employee Assistant Program)
- Vermont Department of Labor
- VABIR
- HireAbility VT
- Goodwin University
- Vermont Youth Conservation Corp.

**Optional community providers - check only those I authorize**

My signature does not authorize a community provider below unless I check that provider. The Core ICAN Team and any community providers I check may communicate with one another and share the information I authorize on this form for the purposes I authorize.

☐ Primary Healthcare Provider: _____
☐ Mental Health/Substance Use Provider: _____
☐ Housing Assistance Provider: _____
☐ Probation and Parole Officer: _____

☐ Restorative Justice: _____
☐ Adult Basic Education: _____
☐ Employer: _____
☐ Agency of Human Services Field Director: _____
☐ Transportation Provider: _____
☐ Community Action (please identify program): _____
☐ Other: _____

**Information I authorize them to share**
Check all that apply. The Core ICAN Team and any community providers I selected may communicate with one another and disclose the checked information.

☐ Relevant information from a healthcare and/or mental health provider concerning my physical or mental health
☐ All substance use disorder patient records
☐ Only the following substance use disorder patient records:
- ☐ Diagnostic information
- ☐ Lab tests
- ☐ Trauma history
- ☐ Medications and dosages
- ☐ Allergies
- ☐ Summary elements of a medical record
- ☐ Substance use history summaries
- ☐ Claims or encounter data
- ☐ Employment information
- ☐ Living situation and social supports

**Purposes for sharing information**
Check all that apply.

☐ To determine the services I need
☐ To coordinate services across all Core ICAN Team members
☐ To transfer my records to the ICAN team in a new location
☐ To consult with professionals associated with the ICAN team in my region when needed
☐ Other: _____

**By signing this form, I understand**
- Why I am being asked to release information.

- My signature authorizes all members of the Core ICAN Team listed on this form.
- Only the optional community providers I check are included in this authorization.
- I do not have to agree to the release of information. However, if I do not give authorization, I may not be able to participate in services available through ICAN.
- If I choose not to sign this form, Economic Services Division benefits to which I or my family are entitled will not be affected.
- While ICAN takes every precaution to protect my health information, once it is disclosed pursuant to this authorization, it may be subject to re-disclosure.
- My substance use disorder patient records are protected under 42 C.F.R. 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. I may revoke this authorization at any time by contacting my ICAN Case Manager. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred.
- If I do not revoke or update this authorization, it will remain in effect for as long as I am receiving ICAN services.
- I will be provided with a copy of this form.
- The items on this form have been explained to me, and my questions about this form have been answered.

**Authorization and signatures**

By signing below, I authorize all Core ICAN Team members listed in this form, plus any optional community providers I checked, to communicate with one another and disclose the types of information I checked for the purposes I checked.

**Participant signature: _____ Date: _____**
**Legal representative signature (if applicable): _____**
**Date: _____**
**Name of person explaining authorization process: _____**
**Organization/Position: _____ Date: _____**