AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____ authorize ____
(consumer first and last name) (name of facility or provider)

To give the Brain Injury Association of Vermont (BIAVT) my contact information on this form, for referral purposes only, so that BIAVT may reach out to me (or my family) to offer assistance and resources. I understand I may revoke this authorization at any time by notifying BIAVT in writing at 1 Derby Lane; Suite 2, Waterbury VT 05676. Otherwise, this form will expire one year from the date indicated at the bottom.

I would like to be contacted by (check all that apply and provide contact information)

- ☐ I would like a phone call at this number:
- ☐ I would like an email at this email address:
- ☐ I would like a brain injury information & resource packet mailed to me at this address:

____
(Consumer Signature) (Date)

____
(Consumer Printed name)

____
(Facility employee/representative/provider name)

Facility: Fax this form to BIAVT at 802-244-4005 or scan and email it to referrals@biavt.org
For questions: call 1-802-244-6850