



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)

LAST NAME- FIRST NAME- MIDDLE NAME DATE OF BIRTH (mm/dd/yyyy)

PATIENT'S MAILING ADDRESS (including City, State and Zip Code)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for: TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify below):

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided: HEALTH SUMMARY (Prior 2 Years) PATIENT MEDICAL RECORDS (Dates): INPATIENT DISCHARGE SUMMARY (Dates): PROGRESS NOTES: SPECIFIC CLINICS (Name & Date Range): SPECIFIC PROVIDERS (Name & Date Range): DATE RANGE: OPERATIVE/CLINICAL PROCEDURES (Name & Date): LAB RESULTS: SPECIFIC TESTS (Name & Date): DATE RANGE: RADIOLOGY REPORTS (Name & Date): LIST OF ACTIVE MEDICATIONS: VACCINATION (Dose, Lot Number, Date & Location): ADMINISTRATIVE RECORDS: OTHER (Describe):

LAST NAME- FIRST NAME- MIDDLE NAME		DATE OF BIRTH (mm/dd/yyyy)
<b>SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.</b>		
I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.		
<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE <input type="checkbox"/> SICKLE CELL ANEMIA <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (HIV)		
I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure.		
<input type="checkbox"/> <b>I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.</b>		
<b>AUTHORIZATION:</b> I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.		
I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.		
<b>EXPIRATION:</b> Without my express revocation, the authorization will automatically expire (select one of the following):		
<input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED		
<input type="checkbox"/> ON (mm/dd/yyyy) _____ (enter a future date other than date signed by patient)		
<input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____		
PATIENT SIGNATURE (Sign in ink)		DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT	
<b>FOR VA USE ONLY</b>		
TYPE AND EXTENT OF MATERIAL RELEASED		
DATE RELEASED (mm/dd/yyyy)		RELEASED BY: