DEPARTMENT OF VETERANS AFFAIRS

In Reply Refer To:

I hereby authorize the above named health care entity to release my protected health information as indicated below to the Department of Veterans Affairs. The purpose of the disclosure is to assist Veterans Health Administration (VHA) clinical staff with my continuity of treatment or to assist VHA investigators in conducting an approved VA research protocol for which I am a subject. Any radiology films or laboratory slides will be returned after review.

Information to be released: From _____ to _____ or as specified below.

☐ Discharge Summary _____

☐ History and physical exam _____

☐ Laboratory Information _____

☐ Radiology Reports _____

☐ Other:_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by placing my initials next to the condition, I am specifically authorizing the release of the information relating to:

☐ Substance Abuse (including alcohol/drug abuse) _____ (initials)

☐ Mental Health _____ (initials)

☐ Psychotherapy Notes _____ (initials)

☐ HIV related information (including HIV related testing) _____ (initials)

- 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 the health entity identified above may not condition treatment, payment, enrollment or eligibility for benefits upon my signing this authorization.

- I understand that I may revoke this authorization in writing to the health care entity at any time except to the extent that action has already been taken to comply with it.

- Without my express revocation, this consent will automatically expire after the requested information has been supplied to VA. I understand that I will receive a copy of this form after I sign it.

- I understand that redisclosure of my health records by those receiving the authorized information may be accomplished without my further written authorization and may no longer be protected by Federal laws or regulation.

(Signature of Patient or Authorized Representative) *(Date)*

Print Patient Name or Authorized Representative) *(Status of Authorized Representative : Guardian/POA)*

NOTE: Please send a copy of this request along with the health information requested to the above VA address.