Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. 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. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

Northport VA Medical Center
79 Middleville Road
Northport, NY 11768

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH
Client, Ignatius, M.	6789	04/15/1970

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

Lisa M. Lawyer
1572 Lawyer's Office Way
Atlanta, GA 30303

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- [X] DRUG ABUSE
- [X] SICKLE CELL ANEMIA
- [X] ALCOHOLISM OR ALCOHOL ABUSE
- [X] HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

- [ ] HEALTH SUMMARY *(Prior 2 Years)*
- [ ] 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 _____
- [X] OTHER *(Describe)*: Please release any and all records pertaining to my treatment in the possession or control of _____ to include, without limitation, any form of mental health treatment. I request that both sensitive and non-sensitive records be released. Please release such records without exclusion or redaction to the person/entity identified above.

PURPOSE(S) OR NEED

Information is to be used by the individual for:

- [ ] TREATMENT
- [ ] BENEFITS
- [X] LEGAL
- [ ] OTHER *(Specify below)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH
Client, Ignatius, M.	6789	04/15/1970

AUTHORIZATION

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.

EXPIRATION

Without my express revocation, the authorization will automatically expire.

☒ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
Client Signature	
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY: