

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. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. 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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

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08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required	
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)	
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (www./dd/www.)
LAST NAIVIE- FIRST NAIVIE- WIIDDLE NAIVIE	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	<i>i</i>):
INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided	ed:
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 DECORDS:	
ADMINISTRATIVE RECORDS:	
OTHER (Describe):	

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LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/ad/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPI	RIATE, COMPLETE WHEN REI	LEASE IS FOR ANY PUR	POSE
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertain	ning to the condition(s) belonger	ow for the non-treatment purpose(s)
DRUG ABUSE ALCOHOLISM OR ALCOHOLISM	HOL ABUSE SICKLE	CELL ANEMIA	
HUMAN IMMUNODEFICIENCY VIRUS (HIV)			
I understand that information on these sensitive diagnos released even if the boxes are unchecked <u>unless</u> I indica disclosure.			
I do not want sensitive diagnoses released for to the other future requests unrelated to this authorized.		specific authorization. I	realize this does not impact
AUTHORIZATION: I certify that this request has be accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the exten receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c it that action has already been ta y housing records. Any disclosu	opy of this form after I sinken to comply with it. Where of information carries	gn it. I may revoke this ritten revocation is effective upon
I understand that the VA health care provider's opinions benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	orization will automatically expire	(select one of the followi	ng):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED			
ON (mm/dd/yyyy) (enter a future date other than date signed by patient)			
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)		D	ATE (mm/dd/yyyy)
, 6			, , , , , , , , , , , , , , , , , , , ,
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)	Di	ATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PA	TIENT
	FOR VA USE ONLY		
TYPE AND EXTENT OF MATERIAL RELEASED			
DATE RELEASED (mm/dd/nnn)	RELEASED BY:		

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