

Instructions for VA Release of Information

Page 1: Complete top portion to include name, date of birth, and complete mailing address

Page 2: At the very top, fill in name and date of birth

In the section that is labeled: SENSITIVE DIAGNOSES: Review and, if appropriate, complete when release is for any purpose other than treatment.

It is very important that you initial the boxes labeled *Drug Abuse* and *Alcoholism or Alcohol Abuse*.

If you fail to initial these boxes the VA Representative will be unable to share any information about those things to the VTC team and it could impact the decision of the court allowing participation.

Once you complete this section please sign and date the form.

FYI: Legal representation does not need to sign the form.

Thank you,

VTC Court Coordinator



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)
7400 Merton Minter Blvd. San Antonio, TX 78229
Any other VHA hospital or outpatient clinic where veteran is or has received treatment.

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
The Comal County Veterans Treatment Court - 199 Main Plaza, New Braunfels, Texas 78130
All affiliated individual agencies, attorneys, and court staff.

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): All drug/alcohol toxicology screens past and future
DATE RANGE:
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS: All medications past and future
VACCINATION (Dose, Lot Number, Date & Location):
ADMINISTRATIVE RECORDS:
OTHER (Describe): All medical record information deemed relevant by VJO past and future

LAST NAME- FIRST NAME- MIDDLE NAME		DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT. 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"/> 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.		
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 (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 checked="" type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): Upon completion or discharge from the court program and associated supervision, which may go beyond completion of the actual court program.		
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	
FOR VA USE ONLY		
TYPE AND EXTENT OF MATERIAL RELEASED VJO will provide summary of progress via written, verbal, telephonic and secured email that is required by court for monitoring of patient's progress in treatment and compliance with legal conditions of Veterans Treatment Court (VTC) participation, inclusive of all relevant medical record information past, present and future. Information will include, but is not limited to: diagnoses, relevant labs, prognosis and treatment, progress in treatment programming, developmental, social, financial and military data as relevant to court/legal circumstances to the designated court team and additional guests as permitted by the authorization. Information will be shared at regular intervals as needed by VJO to VTC to adequately assess progress and compliance. Information relevant to or impacting clinical treatment will be shared with VTC and VHA staff. Medical record information is subject to being discussed in an Open Docket Review.		
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:	