



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK 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 it 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 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. VA 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", 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 Address of VA Health Care Facility)

Orlando VA Medical Center Viera OPC
2900 Veterans Way, Melbourne, FL 32940

LAST NAME- FIRST NAME- MIDDLE INITIAL

LAST 4 SSN

DATE OF BIRTH

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

National Veterans Homeless Support, Inc. (NVHS)
1436 King St., Cocoa, FL 32922 (321) 208-7562

PURPOSE(S) OR NEED: Information is to be used by the individual for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify) Eligibility for Housing & Financial Svcs.

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:
FLU VACCINATION (Dose, Lot Number, Date & Location):
OTHER (Describe): Demographics, verification of military service (DD214), VA Medical & benefits eligibility & history, & living situation detail

LAST NAME- FIRST NAME- MIDDLE INITIAL		LAST 4 SSN	DATE OF BIRTH
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 (<i>HIV</i>) 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. <input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED <input type="checkbox"/> ON _____ (<i>enter a future date other than date signed by patient</i>) <input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____ _____			
PATIENT SIGNATURE (<i>Sign in ink</i>)		DATE (<i>mm/dd/yyyy</i>)	
LEGAL REPRESENTATIVE SIGNATURE (<i>if applicable</i>) (<i>Sign in ink</i>)		DATE (<i>mm/dd/yyyy</i>)	
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT	
FOR VA USE ONLY			
TYPE AND EXTENT OF MATERIAL RELEASED			
DATE RELEASED		RELEASED BY:	