

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)*

MEDVAMC, 2002 Holcombe Blvd, Houston, TX 77030

Any VHA hospital or outpatient clinic (CBOC) and Readjustment Counseling Center where Veteran receives or has received treatment.  
Any mental health or substance abuse treatment provided through Mission Act providers.

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

Liberty County Veterans Court (3rd floor) (1923 Sam Houston St., Liberty TX 77575), Liberty County District Attorney's Office (1st floor) (1923 Sam Houston St., Liberty TX 77575), and all affiliated individuals, agencies, attorneys, and additional invited guests of the court.

**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):* Drs. Nadaban or Poole☐ 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 RECORDS: \_\_\_\_\_☒ OTHER *(Describe):* Summary of MD evaluation;all relevant medical record information needed

LAST NAME- FIRST NAME- MIDDLE NAME		DATE OF BIRTH (mm/dd/yyyy)
<b>SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.</b> 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. <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 60%;"> <input checked="" type="checkbox"/> DRUG ABUSE                <input checked="" type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE                <input type="checkbox"/> SICKLE CELL ANEMIA   <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (HIV)         </div> <div style="width: 35%; font-size: small;">           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"/> <b>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.</b> </div> </div>		
<b>AUTHORIZATION:</b> 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.		
<b>EXPIRATION:</b> 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): <u>Upon completion or discharge from Veterans Court and any associated probation which may last longer than court program.</u>		
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	
<b>FOR VA USE ONLY</b>		
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 progress in treatment and compliance with legal conditions of the Veterans Treatment Court participation, inclusive of all medical record information both past and future. Information will include but not limited to : eligibility for VA services, summary of MD assessment for court, diagnoses (medical, mental health, and substance/alcohol), relevant labs, medical diagnoses, ongoing 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 authorization. Information will be shared at regular intervals as needed by the court team to adequately assess progress of Veteran and compliance with court and probation guidelines. Medical record information is subject to review in open court docket. If found ineligible for the Liberty County Veterans Court Program, disclosure will be limited to military history, VHA eligibility and lack of clinical support for admission to the Veterans Court from MD assessment required for the application process.		
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:	