



Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE OF MEDICAL RECORDS OR HEALTH 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 expect that the time expended by all individuals completing this form will average 2 minutes. This includes the time to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to specifically outline the circumstances under which we may disclose data

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 Social Security Number (SSN) (the SSN will not be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: Department of Veterans Affairs (Print or type name and address of Health care facility) VA Puget Sound Health Care System 1660 S. Columbian Way, Seattle, WA 98108	PATIENT NAME (Last, First, Middle Initial)
	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED.
PATIENT WILL INITIAL ALL OF THE BELOW APPLICABLE TO THIS AUTHORIZATION TO RELEASE.

Bellwether Housing Bread of Life Mission BitFocus Homeless Management Information System Capitol Hill Housing
 Catholic Community Services Catholic Housing Services Chief Seattle Club Community Psychiatric Clinic Compass Housing Alliance
 Congregations for the Homeless DESC El Centro de la Raza Evergreen Treatment Services/REACH Harborview Medical Center
 Housing Authorities: King, Seattle, Renton Hopelink Imagine Housing ITFH King County Department of Community & Human Services
 LIHI Multi Service Center NAVOS Operation Nightwatch Pioneer Human Services Plymouth Housing Group Salvation Army
 Seattle Indian Health Center Seattle-King County Public Health Seattle Human Services/Office of Housing SHARE/WHEEL
 Sound Mental Health Solid Ground St. Vincent de Paul Therapeutic Health Services Union Gospel Mission United Way King County
 Valley Cities Counseling & Consultation Vietnam Veterans Leadership Program Washington State Department of Veterans Affairs YWCA
 Other: _____

SELECT ALL LISTED AGENCIES

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 the information to be released include information regarding the following condition(s):

DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE HUMAN IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA

INFORMATION REQUESTED: (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT NOTE(S) OTHER (Specify) VA medical,
 Answers from VI-SPDAT/VI-Family-SPDAT survey, demographic information, veteran status, income amount and source, legal information, use of case management, and VA healthcare eligibility.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
 For intake purposes, housing placement and referral, case management, coordination.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on year of signature (date supplied by patient: or (3) under the following condition(s): *Discharge from the VA Community Housing and Outreach Services programs. NOTE: The authorization signed on this release will not exceed one year from the date signed.*

Date:	Signature of Patient or Person Authorized to Sign for Patient
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FOR VA USE ONLY

IMPRINT Patient Data Card (Name, Address, Social Security Number)	Type and Extent of Material Released	
	Date Released	Released By: