Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0260), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

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. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

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

TO: **Department of Veterans Affairs**
Atlanta VA Health Care System
Attn: Medical Records Department
1670 Clairmont Road
Decatur, GA 30033

PATIENT NAME (Last, First, Middle Initial)
X

SOCIAL SECURITY NUMBER
X

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED.
Henry County Veterans Treatment Court: County Court and Administration Staff, Private Attorney, Public Defender, Community Supervision Officers and Staff, Family Members, Jail Staff, Vet Center and Staff, Community/Private Medical, Mental Health and Substance Use Treatment Programs.

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

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH 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
TX Summary: Initial Assessment, Diagnoses, Medications, Treatment Plans, UA Results, Psychotherapy Progress Notes, Psychological Testing Results, Family Therapy Notes, Discharge Summaries, and Test Results (COVID 19, TB and RPR). Reporting of progress during treatment (medical, mental health and substance use treatment).

Purpose(s) or need for which the information is to be used:
☒ Assist client in meeting legal requirements ☒ Coordination of Care ☒ Transfer Tx to another agency ☒ Assist with housing ☒ Other: Medical, Mental Health and Substance Use Treatment Psychotherapy and Progress Notes from providers outside of the VA.

AUTHORIZATION: I provide consent to participate in tele-health services and to have my personal health information released via tele-health access with Veterans Treatment Court. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on : or (3) under the following condition(s):

Date:	**Signa**ture of Patient **or Person** Authorized **to Sign for Patient**
X	X

FOR VA USE ONLY

IMPRINT Patient Data Card (Name, Address, Social Security Number)

Type and Extent of Material Released

Date Released	Released By:

VA FORM **10-5345 (R) (663 Automated)**