

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 is 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.

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TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Address of VA Health Care Facility)							
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							
PURPOSE(S) OR NEED: Information is to be used by the individual for:							
TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please sp	pecify)						
INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to	o 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):							

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LAST NAME- FIRST NAME- MIDDLE INITIAL				LAST 4 SSN	DATE OF BIRTH	
SENSITIVE DIAGNOSES: REVIEW AND, IF OTHER THAN TREATMENT.	APPROPRIATE, COMPLE	TE WHEN REI	EASE IS FOR	ANY PURPOSE		
I request and authorize Department of Vete purpose(s) listed in this authorization.	rans Affairs to release the	information p	ertaining to the	e condition(s) bel	ow for the non-treatment	
☐ DRUG ABUSE ☐ ALCOHOLISM	OR ALCOHOL ABUSE	SICKLE	CELL ANEMIA			
HUMAN IMMUNODEFICIENCY VIRUS (HIV)					
I understand that information on these sensitive released even if the boxes are unchecked <u>unledisclosure</u> .						
I do not want sensitive diagnoses release other future requests unrelated to this		es under this	specific autho	rization. I realize	this does not impact	
AUTHORIZATION: I certify that this requaccurate and complete to the best of my know authorization in writing, at any time except to receipt by the Release of Information Unit at unauthorized redisclosure, and the information	wledge. I understand that I vote the extent that action has the facility housing records on may not be protected by	will receive a calready been to s. Any disclosi federal confident	copy of this formaken to comply ure of information entiality rules.	n after I sign it. I with it. Written ro on carries with it	may revoke this evocation is effective upon the potential for	
I understand that the VA health care provide benefits or, if I receive VA benefits, their am Regional Office that specializes in benefit de	ount. They may, however,					
EXPIRATION: Without my express revocation	, the authorization will autor	matically expire	١.			
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED						
ON (enter a future date other than date signed by patient)						
UNDER THE FOLLOWING CONDITION	(S):					
PATIENT SIGNATURE (Sign in ink)				DATE (m.	m/dd/yyyy)	
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)			DATE (m.	DATE (mm/dd/yyyy)		
PRINT NAME OF LEGAL REPRESENTATIVE RELATIONSH		IP TO PATIENT				
	FOR VA	USE ONLY				
TYPE AND EXTENT OF MATERIAL RELEASED						
DATE RELEASED	RELEASED BY:					

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