Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO THE CHOICE/PC3 PROGRAM

Privacy Act Information: 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, (HIPAA) 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. 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 systems of records notices identified as 24VA10P2 "Patient Medical Record -VA" in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you do not, the Contractor will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. VA may also use this information on this form to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

Patient Full Name
Last: (print) _____ **First:** _____ **Middle:** _____

Birth Date (mm/dd/yyyy): _____ **Last four of SSN:** _____

Requestor Name:

Information Requested: Pertinent health information from the health record for my referral or appointment.

I request and authorize VHA and its Contractor to release my protected health information (PHI) for treatment purposes only to the Non VA Providers that are participating in the Choice/PC3 Program Network. This information may consist of the diagnosis of Sickle Cell Anemia, the treatment of or referral for Drug Abuse, treatment of or referral for Alcohol Abuse or the treatment of or testing for infection with Human Immunodeficiency Virus. This authorization covers the diagnoses that I may have upon signing of the authorization and the diagnoses that I may acquire in the future including those protected by 38 U.S.C. § 7332.

This authorization will remain in effect for the period of two years from the date of signature. 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 my VA health care facility. Once VA discloses my health information pursuant to this authorization it may no longer be protected by federal law. Re-disclosure of my health records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected by Federal Law.

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.

_____ _____
Signature of Patient **Date**