Consent for Release of Confidential Health and/or Mental Health Information

DOC Facility Name: _____

Address: _____

Telephone #: (____) _____ Fax #: (____) _____

Inmate/Probationer/Parolee Name:		DOC #:	
DOB:		SS#:	

I hereby authorize: _____ (____) _____ (____) _____
Name and title of organization/practitioner/person *Phone #* *Fax #*

_____
Street Address *City* *State* *ZIP*

to release/use/disclose the following information: **(Check all that apply)**

☐ Discharge Summary(ies) ☐ Mental Health Evaluation(s)
☐ Consultations ☐ Progress Notes ☐ Physician Orders
☐ Lab Work ☐ Treatment Plans ☐ Risk Assessments
☐ History and Physical ☐ Substance Abuse Information* ☐ Entire Medical Record
☐ Other: _____

Per Federal Confidentiality Rules (42 CFR part 2), I am expressly permitting the specific release of substance abuse related information: ☐ YES ☐ NO _____ Inmate/Probationer/Parolee's initials

Per Federal Confidentiality Rules (115.8[e], I am expressly permitting the specific release of prior sexual victimization that did not occur in an institutional setting, and I am an adult (18 years or older) ☐ YES ☐ NO _____ Inmate/Probationer/Parolee's initials

Per COV §32.1-36.1, I am expressly permitting the specific release of HIV/AIDS related information: ☐ YES ☐ NO _____ Inmate/Probationer/Parolee's initials

To: _____ (____) _____ (____) _____
Name and title of organization/practitioner *Phone #* *Fax #*

_____
Street Address *City* *State* *ZIP*

Purpose of release/use/disclosure of information is: ☐ Diagnosis/Treatment ☐ Discharge Planning ☐ (other)_____

As the person signing this authorization, I acknowledge that I am giving permission to the above named individual or entity to disclose and use protected health care information. I have been informed that:

- DOC cannot make the provision of treatment to me conditional upon my signing of this authorization
- The original of this authorization shall be included in my Health Record and a notation concerning the individuals or entities to which disclosure was made shall be included with my original records
- I have the right to revoke this authorization at any time. I understand that the revocation is not effective until delivered in writing to the person in possession of my records
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Unless revoked, this authorization will expire: (specify date or event):_____

This information may be disclosed effective: ☐ Immediately ☐ _____ (specify date)

_____ _____
Signature (Inmate/Probationer/Parolee) Date

_____ _____ _____
Signature (Witness) Printed Name (Witness) Date

cc: Inmate/Probationer/Parolee Health Record