



Consent for Release of Confidential Health and/or Mental Health Information (Inactive Inmate Only)

DOC Facility Name: _____ Fax#: () _____

Address: _____ Tel#: () _____

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

Per Federal Confidentiality Rules (42 CFR part 2), I am expressly permitting the specific release of substance abuse related information: ☐ YES
☐ NO _____ Inactive inmate initials

Per Federal Confidentiality Rules (115.8f), 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 _____ Inactive inmate initials

Per COV §32.1-36.1, I am expressly permitting the specific release of HIV/AIDS related information: ☐ YES ☐ NO _____ Inactive inmate
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 will be included in my Health Record and a notation concerning the individuals or entities to which disclosure was made will 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 (Inactive Inmate) _____ Date _____

FOR NOTARY PUBLIC'S USE ONLY:

State of _____ [] City [] County of _____ Acknowledged, subscribed and sworn to
before me this _____ day of _____, 20____.

Notary Name _____

Notary Registration Number _____

Notary Public's Signature _____

(My commission expires: _____)

