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: _____ SSN#: _____

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 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: _____)