Consent to Release Confidential Health and/or Mental Health Information (Inactive Only)

DOC Facility Name: _____ **Fax #:** _____

DOC Facility Address: _____ **Phone #:** _____

_____

Inactive Inmate Name: _____ **DOC #:** _____

Date of Birth: _____ **SSN:** _____

I hereby authorize the record holder(s): _____

Street Address _____ **Fax #:** _____

_____ **Phone #:** _____

City **State** **ZIP**

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

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

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

Information may be disclosed effective: ☐ Immediately ☐ Specific Date: _____

_____ _____
Inactive Inmate Signature *Date*

FOR NOTARY PUBLIC'S USE ONLY:

State _____ ☐ **City** ☐ **County** **of** _____

Acknowledged, subscribed, and sworn to before me this _____ **day of** _____ **in the year** _____

_____ _____
Notary Registration Number *Notary Commission Expires on the Above Date*

_____ _____
Notary Public's Name *Notary Public's Signature*