Full Name - *First Last (Order)* Full Name - *Last, First (Order)* Veteran Social Security Number Veteran Last 4 Social Security Number Date forms will be signed (If Known) Phone #

Mailing Address Date of Birth Veteran being referred to: Low Demand Bridge Housing Clinical Treatment Service Intensive Transition-In-Place - <u>FAMILIES ONLY</u> (see page 2 for bed type descriptions)

ROI Pages Please see note below for ROI information the Veteran will need to complete prior to signing

Aspire Cocoa	5-6
Transition House	7-8
Halifax (HUM)	9-10
VTF	11-12
VOA	13-14
Bridges	15-16
HFH	17-18
Aspire Orange	19-20
Family Promise	21-22

# Information required by GPD programs - to be completed on ROI form by Veteran:

Health Summary; Progress Notes (Primary Care, Social Work, Mental Health); Lab results (PPD, QuantiFERON); Radiology Reports; List of Active Medications; Other (information as needed pertaining to housing needs); Sensitive Diagnoses: Drug Abuse, Alcoholism or Alcohol Abuse, Sickle Cell Anemia, Human Immunodeficiency Virus (HIV); Expiration: 30 days after discharge from program.

\*Veteran has the right to decline to share the above information, but failure to provide may result in admission delay or denial of the referrral\*

Zip Code

# **Orlando VAHCS**

# **Current models of GPD Programs Available**

#### Low Demand (Aspire-Orlando, Halifax Urban Ministries, Housing for Homeless):

- Targeted Population Veterans who:
  - Are chronically homeless
  - Are diagnosed with mental health and/or substance use disorders
  - Struggle with maintaining sobriety
  - Have a history of multiple treatment failures
  - Have never engaged in treatment services and/or are in pre-contemplation
- A *harm reduction* model to better accommodate chronically homeless Veterans and Veterans who were unsuccessful in traditional treatment settings.
- Programming does NOT require sobriety or compliance with mental health treatment as a condition of admission or continued stay.
- Overall demands are kept to a minimum; however, services are made widely available and are actively promoted by program staff.

# • Goal - establish permanent housing in the community while ensuring the safety of staff and residents **Bridge Housing (Aspire-Brevard, Housing for Homeless, VOA, VTF)**:

- Targeted Population Homeless Veterans that have been offered and accepted a permanent housing intervention (e.g., SSVF, HUD-VASH, Housing Coalition/CoC) but, are not able to immediately enter the permanent housing.
- Length of Stay (LOS) is individually determined based on need but, in general not expected to exceed 90 days.
- Goals are short-term with the focus on the move to permanent housing, rather than the completion of treatment goals.
- Veterans are expected to receive case management and support which should be coordinated with the applicable HUD-VASH or SSVF team.

#### Clinical Treatment (Transition House, VOA):

- Targeted Population Homeless Veterans with a specific diagnosis related to a substance use disorder and/or mental health diagnosis; Veteran actively chooses to engage in clinical services.
- Clinically focused treatment provided in conjunction with supportive housing and services
- Clinical Treatment GPD Programs:
  - Incorporate strategies to increase income and permanent housing attainment
  - Complete individualized assessments, services, and treatment plans
  - Have licensed and/or credentialed staff for the SUD/MH services provided

#### Service Intensive (Aspire-Brevard, Aspire-Orlando, Bridges, Housing for Homeless, VOA, VTF):

- Targeted Population Homeless Veterans who choose a supportive transitional housing environment providing services prior to entering permanent housing.
- Provides transitional housing and a milieu of services that assist Veterans in increasing income and moving into permanent housing.

#### Transition-In-Place (Family Promise):

- Targeted Population Homeless Veterans and Veteran families who are likely to be able to self-sustain a residence and rental payments after a transitional period of supportive services.
- Provides housing in which supportive services transition out of the residence over time, rather than the resident. Upon completion of TIP services, the resident retains the unit as their permanent housing with no requirement to move.

# Orlando VA Healthcare System

# **GPD Transitional Housing Referral Application**

		Date:						
Housing for Homeless (LD, SI, BH) Send referrals to: Steve@housingforhomeless. org P: (321) 639-0166 ext 205	Send Fax: (3 vtfdired	VTF SI, BH) <i>referrals to:</i> 21) 409-8168; e-mail: ctormelbourne gmail.com	Fax: jgou	(9) ad ref (321) e-n ild@1 .0	<b>dges</b> 51) <i>Ferrals to:</i> ) 752-3218 nail: mybridges org <b>Dnly Site</b>	Aspire-H (SI, 1 Send refe Chelsea.Adkins P: (407) 875-3 Fax: (321) Female O	<b>BH)</b> <i>rrals to:</i> @aspirehp.org 700 ext 4924 504-2028	VOA (SI, CT, BH) Send referrals to: Fax: (321) 806-3056 e-mail: ptilbanie@voa- fla.org
Transition House-O (CT) Send referrals to: Fax: (321) 805-328. e-mail: lshiflett@thetransitionhou donna@thetransitionhou Male Only Sit	4 use.org use.org	Halifax Urbaı Volusia Send refe pamela.kye For referral BrandyC@halifax .or p: (386) 252-	<b>a (LD)</b> errals to: er@va.gov follow-up kurbanmin rg;	: iistries	(SI Send re Fax: (40 For referr Phillip.McCorn	E- <b>Orlando I, LD)</b> <i>iferrals to:</i> 17) 667-1619 val follow-up: nick@aspirehp.org <b>Only Site</b>	Email refer cberg@family	Promise (TIP) rrals to: /promiseorlando.org lies Only
Referring Agency: Referring Staff Name:				Re	eferring Sta	ff Contact Inf	ormation:	
Veteran Name:				SS#	:			
Address:				Zip:				
Phone:			D.0	.B:				
Is Veteran Eligible for Medical Care at the VA?			VA?		Yes	No Un	certain	
How many prior GPD	(VA Tr	ansitional Ho	ousing)	stay	vs does the V	Veteran Repo	rt?	
Are there legal housin	g restri	ctions?			Yes	No Un	certain	
Identified Gender:								
Marital Status:				# of	Children in	Custody:		
Current Income/Sour								
Describe current livin services:	g situat	ion, including	; if hon	ieles	s and brief	y explain nee	1 for housing	and support

	TT D 1 . 1T	0					
Mental Health Diagnosis/Substance	e Use Related Iss	sues?:					
Can the Veteran manage his/her AD	Ls (bathing, dre	ssing)?	Yes	No			
List any medical equipment or mobi	lity needs.						
Does Veteran have any medications	s that require ref	rigeration?	Yes		No		
Deer Wetenen bereiten og den men be	•		1: .		11 1		
Does Veteran have a 30 day supply	NT. NT.	Are any of the					
of current medications?	Yes No	Substantees (			azepines,	Yes	No
		methamphe	etamines,	etc)?			
Is the Veteran prescribed any medication assisted therapeutics (Methadone, Voc. N				No			
Suboxone, Subutex, etc)?				NU			
If Imorum, placed list any pending (up	a mina madiaal	/montal health	annaint	montao	nd/on oong	-l+a.	
If known, please list any pending/up	bcoming medical	/ mental nearth	i appoint	ments a	nd/or cons	ints:	
Vaccinated for COVID? Y	N If yes, date	of final dose:					

# PLEASE SEND THE FOLLOWING IF YOU HAVE ACCESS

Ambulatory Care Note Current PPD or Chest X-Ray or QuantiFERON

Most Recent Psychosocial, Social Work, HCHV and/or Mental Health Note

Release of Information for VA (below) to GPD Program

Release of Information for Referring Agency to GPD Program

HOMES Report (If you have access)

*If you have questions, please contact the program directly* or you can contact the VA GPD liaison for additional information (please encrypt emails if they contain any PHI):

Shannon Moroff – ASPIRE Orange (Men)

3<sup>21-</sup>689-7157 Shannon.Moroff@va.gov

Marlena Croll – Transition House

407-782-5882 Marlena.Croll@va.gov

Pamela Kyer – Halifax Urban Ministries

407-760-0471

## Nancy Burden – VOA

321-637-3788 x43791 Nancy.Burden@va.gov

Pamela.Kyer@va.gov

Melissa Outman- Housing for Homeless, Aspire Cocoa (Women)

321-637-3788 x43791 Melissa.Outman@va.gov

## Ernest Duncklee - VTF, Bridges

321-637-3788 x43791 Delbert.Duncklee@va.gov

Department of veterans Analis	RELEASE HEALTH INFORMATION
PRIVACY ACT STATEMENT:	
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a requested on this form is voluntary. However, if information needed to locate comply with the request. The Veterans Health Administration may not condit eligibility for benefits on the signing of an authorization, except for research-identifiable health information for such research is required. VA may disclosur "routine use" disclosure of the information as outlined in the Privacy Act systemeters.	e form authorizes release of information in accordance with the Health Insurance a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information e records for release is not furnished completely and accurately, VA will be unable to tion the provision of treatment, payment, enrollment in the VA Health Care Program, or related treatment where an authorization for the use or disclosure of individually- e the information that you put on the form as permitted by law. VA may make a tem of records notices identified as 24VA10A7 "Patient Medical Record - VA", ordance with the Notice of Privacy Practices. VA may also use this information to ords, and for other purposes authorized or required by law.
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of	of the VA Health Care Facility)
Orlando VAHCS (including all facilities at	nd CBOCS within Orlando VAHCS)
13800 Veterans Way Orlando, FL 32827	
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
PATIENT'S MAILING ADDRESS (including City, State and Zip Code	)
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE Aspire Health Partners 3905 Grissom Parkway Cocoa, Florida 32926	
PURPOSE(S) OR NEED: Information is to be used by the requestor f	or:
TREATMENT BENEFITS LEGAL EMPLOY	YMENT OTHER (Please specify below):
INFORMATION REQUESTED: Check applicable box(es) and state the	e extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 Years)	
PATIENT MEDICAL RECORDS (Dates):	
INPATIENT DISCHARGE SUMMARY (Dates):	
PROGRESS NOTES:	
SPECIFIC CLINICS (Name & Date Range):	
SPECIFIC PROVIDERS (Name & Date Range):	
DATE RANGE:	
LAB RESULTS:	
SPECIFIC TESTS (Name & Date):	
VACCINATION (Dose, Lot Number, Date & Location):	
ADMINISTRATIVE RECORDS:	
OTHER (Describe):	

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROP	RIATE. COMPLETE WHEN REI	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s) I	pelow for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnose released even if the boxes are unchecked <u>unless</u> I indica disclosure.	es may be released for treatmer ate by checking the box below th	nt purposes without me nat I do not want this inf	checking the above boxes, and will be ormation released for this specific
I do not want sensitive diagnoses released for t other future requests unrelated to this authoriza		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has bee accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the exten receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after l ken to comply with it. are of information carri	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinions benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
ON (mm/dd/yyyy) (enter a full	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
VA will provide information upon communication that is required by planning. Information will include mental health, and substance/alcohe developmental, social, financial, CERS officials and as permitted by discharge from GPD. DATE RELEASED RELEASED BY VA FORM	GPD program for ad e but may not be li ol), active medicat and military data,	mission, treat mited to: diag ions and preso as deemed rel	rment, and discharge gnoses (medical, criptions, levant by designated
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

Department of veterans Affairs	RELEASE HEALTH INFORMATION
PRIVACY ACT STATEMENT:	
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 55 requested on this form is voluntary. However, if information needed to loca comply with the request. The Veterans Health Administration may not conc eligibility for benefits on the signing of an authorization, except for research identifiable health information for such research is required. VA may disclo "routine use" disclosure of the information as outlined in the Privacy Act sy	he form authorizes release of information in accordance with the Health Insurance 2a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information ate records for release is not furnished completely and accurately, VA will be unable to dition the provision of treatment, payment, enrollment in the VA Health Care Program, or h-related treatment where an authorization for the use or disclosure of individually- ose the information that you put on the form as permitted by law. VA may make a ystem of records notices identified as 24VA10A7 "Patient Medical Record - VA", ccordance with the Notice of Privacy Practices. VA may also use this information to ecords, and for other purposes authorized or required by law.
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location Orlando VAHCS (including all facilities a 13800 Veterans Way	-
Orlando, FL 32827	
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
PATIENT'S MAILING ADDRESS (including City, State and Zip Coa	le)
Transition House 3800 5th Street, St. Cloud, FL 34769 <b>PURPOSE(S) OR NEED</b> : Information is to be used by the requestor	LE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED r for: DYMENT OTHER (Please specify below):
INFORMATION REQUESTED: Check applicable box(es) and state	the extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 Years)	·
PATIENT MEDICAL RECORDS (Dates):	
INPATIENT DISCHARGE SUMMARY ( <i>Dates</i> ):	
PROGRESS NOTES:	
SPECIFIC CLINICS (Name & Date Range):	
SPECIFIC PROVIDERS (Name & Date Range):	
DATE RANGE:	
LAB RESULTS:	
SPECIFIC TESTS (Name & Date):	
RADIOLOGY REPORTS (Name & Date):	
VACCINATION (Dose, Lot Number, Date & Location):	

M

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPI	RIATE, COMPLETE WHEN RE	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s)	below for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnos released even if the boxes are unchecked <u>unless</u> I indica disclosure.			
I do not want sensitive diagnoses released for t other future requests unrelated to this authorization		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has been accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the extent receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after laken to comply with it. are of information carrie	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinion benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
$\square ON (mm/dd/yyyy) \_ (enter a fu)$	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i>	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
VA will provide information upon communication that is required by planning. Information will include mental health, and substance/alcohe developmental, social, financial, CERS officials and as permitted b discharge from GPD. DATE RELEASED RELEASED BY VA FORM	GPD program for ad e but may not be li ol), active medicat and military data,	mission, treat mited to: diag ions and preso as deemed rei	rment, and discharge gnoses (medical, criptions, levant by designated
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

Department of Veterans Affairs	REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION
PRIVACY ACT STATEMENT:	
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U requested on this form is voluntary. However, if information needed comply with the request. The Veterans Health Administration may eligibility for benefits on the signing of an authorization, except for identifiable health information for such research is required. VA ma "routine use" disclosure of the information as outlined in the Privac 08VA05 "Employee Medical File System Records (Title 38)-VA" a	U.S.C. The form authorizes release of information in accordance with the Health Insurance S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information d to locate records for release is not furnished completely and accurately, VA will be unable to not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or research-related treatment where an authorization for the use or disclosure of individually- ay disclose the information that you put on the form as permitted by law. VA may make a y Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", and in accordance with the Notice of Privacy Practices. VA may also use this information to l their records, and for other purposes authorized or required by law.
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and La Orlando VAHCS (including all facilit 13800 Veterans Way	
Orlando, FL 32827 LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
PATIENT'S MAILING ADDRESS (including City, State and 2	Zip Code)
Halifax Urban Ministries-Volusia 605 N Segrave St., Daytona Beach, FL PURPOSE(S) OR NEED: Information is to be used by the re	
INFORMATION REQUESTED: Check applicable box(es) and HEALTH SUMMARY (Prior 2 Years)	state the extent or nature of information to be provided:
PATIENT MEDICAL RECORDS (Dates):	
INPATIENT DISCHARGE SUMMARY (Dates):	
SPECIFIC CLINICS (Name & Date Range):	
SPECIFIC PROVIDERS (Name & Date Range):	
	)•
LAB RESULTS:	):
VACCINATION (Dose, Lot Number, Date & Location):	

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPI	RIATE, COMPLETE WHEN RE	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s)	below for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnos released even if the boxes are unchecked <u>unless</u> I indica disclosure.			
I do not want sensitive diagnoses released for t other future requests unrelated to this authorization		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has been accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the extent receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after laken to comply with it. are of information carrie	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinion benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
$\square ON (mm/dd/yyyy) \_ (enter a fu)$	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i>	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
VA will provide information upon communication that is required by planning. Information will include mental health, and substance/alcohe developmental, social, financial, CERS officials and as permitted b discharge from GPD. DATE RELEASED RELEASED BY VA FORM	GPD program for ad e but may not be li ol), active medicat and military data,	mission, treat mited to: diag ions and preso as deemed rei	rment, and discharge gnoses (medical, criptions, levant by designated
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

Department of Veterans Affairs	REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION
PRIVACY ACT STATEMENT:	
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S requested on this form is voluntary. However, if information needed comply with the request. The Veterans Health Administration may ne eligibility for benefits on the signing of an authorization, except for r identifiable health information for such research is required. VA may "routine use" disclosure of the information as outlined in the Privacy	S.C. The form authorizes release of information in accordance with the Health Insurance S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information to locate records for release is not furnished completely and accurately, VA will be unable to ot condition the provision of treatment, payment, enrollment in the VA Health Care Program, or research-related treatment where an authorization for the use or disclosure of individually- y disclose the information that you put on the form as permitted by law. VA may make a Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", and in accordance with the Notice of Privacy Practices. VA may also use this information to their records, and for other purposes authorized or required by law.
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Loc Orlando VAHCS (including all faciliti 13800 Veterans Way Orlando, FL 32827	
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
PATIENT'S MAILING ADDRESS (including City, State and Zi	ip Code)
Vietnam (and all) Veterans of Brevard 700 E. Fee Avenue, Melbourne, FL 3290 <b>PURPOSE(S) OR NEED</b> : Information is to be used by the req	
INFORMATION REQUESTED: Check applicable box(es) and HEALTH SUMMARY (Prior 2 Years)	state the extent or nature of information to be provided:
PATIENT MEDICAL RECORDS (Dates):	
INPATIENT DISCHARGE SUMMARY (Dates):	
PROGRESS NOTES:	
SPECIFIC CLINICS (Name & Date Range):	
SPECIFIC PROVIDERS (Name & Date Range):	
DATE RANGE:	
	:
	:
OPERATIVE/CLINICAL PROCEDURES (Name & Date): LAB RESULTS:	
OPERATIVE/CLINICAL PROCEDURES (Name & Date):  LAB RESULTS:  SPECIFIC TESTS (Name & Date):  DATE DANCE:	: 
OPERATIVE/CLINICAL PROCEDURES (Name & Date):  LAB RESULTS:  SPECIFIC TESTS (Name & Date):  DATE RANGE:	
OPERATIVE/CLINICAL PROCEDURES (Name & Date):  LAB RESULTS:  SPECIFIC TESTS (Name & Date):  DATE RANGE:  RADIOLOGY REPORTS (Name & Date):  LIST OF ACTIVE MEDICATIONS:	
OPERATIVE/CLINICAL PROCEDURES (Name & Date):  LAB RESULTS:  SPECIFIC TESTS (Name & Date):  DATE RANGE:  RADIOLOGY REPORTS (Name & Date):  LIST OF ACTIVE MEDICATIONS:	
OPERATIVE/CLINICAL PROCEDURES (Name & Date):  LAB RESULTS:  SPECIFIC TESTS (Name & Date):  DATE RANGE:  RADIOLOGY REPORTS (Name & Date):  LIST OF ACTIVE MEDICATIONS:  VACCINATION (Dose, Lot Number, Date & Location):  ADMINISTRATIVE RECORDS:	

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRI OTHER THAN TREATMENT.	IATE, COMPLETE WHEN REI	EASE IS FOR ANY PL	JRPOSE
I request and authorize Department of Veterans Affairs to listed in this authorization.	release the information pertain	ing to the condition(s) b	elow for the non-treatment purpose(s)
DRUG ABUSE ALCOHOLISM OR ALCOH	OL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnoses released even if the boxes are unchecked <u>unless</u> I indicate disclosure.			
I do not want sensitive diagnoses released for tro other future requests unrelated to this authorizat		specific authorization	. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has been accurate and complete to the best of my knowledge. I un authorization in writing, at any time except to the extent receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not be	derstand that I will receive a c that action has already been ta housing records. Any disclosu	opy of this form after I ken to comply with it. are of information carrie	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinions benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
<b>EXPIRATION:</b> Without my express revocation, the author		(select one of the follo	wing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS A			
$ \square ON (mm/dd/yyyy) \_ (enter a futu) $			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i> )	(Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO F	PATIENT
	FOR VA USE ONLY		
TYPE AND EXTENT OF MATERIAL RELEASED			
VA will provide information upon r communication that is required by planning. Information will include mental health, and substance/alcoho developmental, social, financial, CERS officials and as permitted by discharge from GPD.	GPD program for ad but may not be li l), active medicat and military data,	mission, treat mited to: diag ions and presc as deemed rel	ment, and discharge noses (medical, riptions, evant by designated
DATE RELEASED			
RELEASED BY VA FORM			
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

	RELEASE HEALTH INFORMATION
PRIVACY ACT STATEMENT:	
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 5 requested on this form is voluntary. However, if information needed to loc comply with the request. The Veterans Health Administration may not con eligibility for benefits on the signing of an authorization, except for resear identifiable health information for such research is required. VA may disc "routine use" disclosure of the information as outlined in the Privacy Act s	The form authorizes release of information in accordance with the Health Insurance (52a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information cate records for release is not furnished completely and accurately, VA will be unable to ndition the provision of treatment, payment, enrollment in the VA Health Care Program, or ch-related treatment where an authorization for the use or disclosure of individually-lose the information that you put on the form as permitted by law. VA may make a system of records notices identified as 24VA10A7 "Patient Medical Record - VA", accordance with the Notice of Privacy Practices. VA may also use this information to records, and for other purposes authorized or required by law.
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location Orlando VAHCS (including all facilities 13800 Veterans Way	
Orlando, FL 32827	
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
PATIENT'S MAILING ADDRESS (including City, State and Zip Co	pde)
906 Peachtree St, Cocoa, FL 32922         PURPOSE(S) OR NEED: Information is to be used by the requested         TREATMENT       BENEFITS       LEGAL       EMPL	or for: _OYMENT OTHER (Please specify below):
INFORMATION REQUESTED: Check applicable box(es) and state	e the extent or nature of information to be provided:
INFORMATION REQUESTED: Check applicable box(es) and state HEALTH SUMMARY (Prior 2 Years)	e the extent or nature of information to be provided:
	e the extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 Years)	e the extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 Years)     PATIENT MEDICAL RECORDS (Dates):     INPATIENT DISCHARGE SUMMARY (Dates):     PROGRESS NOTES:	e the extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 Years)     PATIENT MEDICAL RECORDS (Dates):     INPATIENT DISCHARGE SUMMARY (Dates):     PROGRESS NOTES:     SPECIFIC CLINICS (Name & Date Range):	e the extent or nature of information to be provided:
<ul> <li>HEALTH SUMMARY (Prior 2 Years)</li> <li>PATIENT MEDICAL RECORDS (Dates):</li> <li>INPATIENT DISCHARGE SUMMARY (Dates):</li> <li>PROGRESS NOTES:</li> <li>SPECIFIC CLINICS (Name &amp; Date Range):</li> <li>SPECIFIC PROVIDERS (Name &amp; Date Range):</li> </ul>	
<ul> <li>HEALTH SUMMARY (Prior 2 Years)</li> <li>PATIENT MEDICAL RECORDS (Dates):</li> <li>INPATIENT DISCHARGE SUMMARY (Dates):</li> <li>PROGRESS NOTES:</li> <li>SPECIFIC CLINICS (Name &amp; Date Range):</li> <li>SPECIFIC PROVIDERS (Name &amp; Date Range):</li> <li>DATE RANGE:</li> </ul>	
<ul> <li>HEALTH SUMMARY (Prior 2 Years)</li> <li>PATIENT MEDICAL RECORDS (Dates):</li> <li>INPATIENT DISCHARGE SUMMARY (Dates):</li> <li>PROGRESS NOTES:</li> <li>SPECIFIC CLINICS (Name &amp; Date Range):</li> <li>SPECIFIC PROVIDERS (Name &amp; Date Range):</li> <li>DATE RANGE:</li> </ul>	
<ul> <li>HEALTH SUMMARY (Prior 2 Years)</li> <li>PATIENT MEDICAL RECORDS (Dates):</li> <li>INPATIENT DISCHARGE SUMMARY (Dates):</li> <li>PROGRESS NOTES:</li> <li>SPECIFIC CLINICS (Name &amp; Date Range):</li> <li>SPECIFIC PROVIDERS (Name &amp; Date Range):</li> <li>DATE RANGE:</li> <li>OPERATIVE/CLINICAL PROCEDURES (Name &amp; Date):</li> <li>LAB RESULTS:</li> </ul>	
<ul> <li>HEALTH SUMMARY (Prior 2 Years)</li> <li>PATIENT MEDICAL RECORDS (Dates):</li> <li>INPATIENT DISCHARGE SUMMARY (Dates):</li> <li>PROGRESS NOTES:</li> <li>SPECIFIC CLINICS (Name &amp; Date Range):</li> <li>SPECIFIC PROVIDERS (Name &amp; Date Range):</li> <li>DATE RANGE:</li> <li>OPERATIVE/CLINICAL PROCEDURES (Name &amp; Date):</li> <li>LAB RESULTS:</li> <li>SPECIFIC TESTS (Name &amp; Date):</li> </ul>	
<ul> <li>HEALTH SUMMARY (Prior 2 Years)</li> <li>PATIENT MEDICAL RECORDS (Dates):</li> <li>INPATIENT DISCHARGE SUMMARY (Dates):</li> <li>PROGRESS NOTES:</li> <li>SPECIFIC CLINICS (Name &amp; Date Range):</li> <li>SPECIFIC PROVIDERS (Name &amp; Date Range):</li> <li>DATE RANGE:</li> <li>OPERATIVE/CLINICAL PROCEDURES (Name &amp; Date):</li> <li>LAB RESULTS:</li> <li>SPECIFIC TESTS (Name &amp; Date):</li> <li>DATE RANGE:</li> </ul>	
<ul> <li>HEALTH SUMMARY (Prior 2 Years)</li> <li>PATIENT MEDICAL RECORDS (Dates):</li> <li>INPATIENT DISCHARGE SUMMARY (Dates):</li> <li>PROGRESS NOTES:</li> <li>SPECIFIC CLINICS (Name &amp; Date Range):</li> <li>SPECIFIC PROVIDERS (Name &amp; Date Range):</li> <li>DATE RANGE:</li> <li>OPERATIVE/CLINICAL PROCEDURES (Name &amp; Date):</li> <li>LAB RESULTS:</li> <li>SPECIFIC TESTS (Name &amp; Date):</li> <li>DATE RANGE:</li> <li>DATE RANGE:</li> <li>RADIOLOGY REPORTS (Name &amp; Date):</li> </ul>	
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M

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROP	RIATE. COMPLETE WHEN REI	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s) I	pelow for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnose released even if the boxes are unchecked <u>unless</u> I indica disclosure.	es may be released for treatmer ate by checking the box below th	nt purposes without me nat I do not want this inf	checking the above boxes, and will be ormation released for this specific
I do not want sensitive diagnoses released for t other future requests unrelated to this authoriza		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has bee accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the exten receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after l aken to comply with it. are of information carri	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinions benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
ON (mm/dd/yyyy) (enter a full	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
<pre>VA will provide information upon request via written, verbal, and secured electronic communication that is required by GPD program for admission, treatment, and discharge planning. Information will include but may not be limited to: diagnoses (medical, mental health, and substance/alcohol), active medications and prescriptions, developmental, social, financial, and military data, as deemed relevant by designated CERS officials and as permitted by authorization. The authorization will expire upon discharge from GPD.</pre> DATE RELEASED RELEASED BY VA FORM			
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

Department of Veterans Affairs	REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION		
PRIVACY ACT STATEMENT:			
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 requested on this form is voluntary. However, if information need comply with the request. The Veterans Health Administration ma eligibility for benefits on the signing of an authorization, except fi identifiable health information for such research is required. VA n "routine use" disclosure of the information as outlined in the Priva 08VA05 "Employee Medical File System Records (Title 38)-VA	U.S.C. The form authorizes release of information in accordance with the Health Insurance U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information led to locate records for release is not furnished completely and accurately, VA will be unable to y not condition the provision of treatment, payment, enrollment in the VA Health Care Program, for research-related treatment where an authorization for the use or disclosure of individually-may disclose the information that you put on the form as permitted by law. VA may make a acy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", " and in accordance with the Notice of Privacy Practices. VA may also use this information to nd their records, and for other purposes authorized or required by law.		
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Orlando VAHCS (including all facili 13800 Veterans Way Orlando, FL 32827	<i>Location of the VA Health Care Facility)</i> ties and CBOCS within Orlando VAHCS)		
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyy		
PATIENT'S MAILING ADDRESS (including City, State and	l Zip Code)		
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL Patriot House, BRIDGES 2452 St. Swithin Ln, Melbourne, FL PURPOSE(S) OR NEED: Information is to be used by the n TREATMENT BENEFITS LEGAL			
INFORMATION REQUESTED: Check applicable box(es) a HEALTH SUMMARY (Prior 2 Years) PATIENT MEDICAL RECORDS (Dates):	nd state the extent or nature of information to be provided:		
INPATIENT DISCHARGE SUMMARY (Dates):			
PROGRESS NOTES:			
SPECIFIC CLINICS (Name & Date Range):			
SPECIFIC PROVIDERS (Name & Date Range):			
DATE RANGE:			
OPERATIVE/CLINICAL PROCEDURES (Name & Da	<i>te)</i> :		
LAB RESULTS:			
SPECIFIC TESTS (Name & Date):			
RADIOLOGY REPORTS (Name & Date):			
LIST OF ACTIVE MEDICATIONS:			
VACCINATION (Dose, Lot Number, Date & Location)	):		
OTHER (Describe):			

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPI	RIATE, COMPLETE WHEN RE	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s)	below for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnos released even if the boxes are unchecked <u>unless</u> I indica disclosure.			
I do not want sensitive diagnoses released for t other future requests unrelated to this authorization		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has been accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the extent receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after laken to comply with it. are of information carri	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinion benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
$\square ON (mm/dd/yyyy) \_ (enter a fu)$	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i>	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
VA will provide information upon communication that is required by planning. Information will include mental health, and substance/alcohe developmental, social, financial, CERS officials and as permitted b discharge from GPD. DATE RELEASED RELEASED BY VA FORM	GPD program for ad e but may not be li ol), active medicat and military data,	mission, treat mited to: diag ions and preso as deemed rel	rment, and discharge gnoses (medical, criptions, levant by designated
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

Department of veterans Affairs	RELEASE HEALTH INFORMATION	
PRIVACY ACT STATEMENT:		
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 55 requested on this form is voluntary. However, if information needed to loca comply with the request. The Veterans Health Administration may not comeligibility for benefits on the signing of an authorization, except for research identifiable health information for such research is required. VA may discle "routine use" disclosure of the information as outlined in the Privacy Act space.	he form authorizes release of information in accordance with the Health Insurance i2a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information ate records for release is not furnished completely and accurately, VA will be unable to dition the provision of treatment, payment, enrollment in the VA Health Care Program, or h-related treatment where an authorization for the use or disclosure of individually- ose the information that you put on the form as permitted by law. VA may make a ystem of records notices identified as 24VA10A7 "Patient Medical Record - VA", ccordance with the Notice of Privacy Practices. VA may also use this information to eccords, and for other purposes authorized or required by law.	
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location Orlando VAHCS (including all facilities		
13800 Veterans Way	and choos within offando vimos,	
Orlando, FL 32827		
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)	
PATIENT'S MAILING ADDRESS (including City, State and Zip Cod	le)	
Housing for Homeless 417 Rockpit Rd. Suite 105, Titusville, F PURPOSE(S) OR NEED: Information is to be used by the requesto TREATMENT BENEFITS LEGAL EMPLO		
<b>INFORMATION REQUESTED:</b> Check applicable box(es) and state	the extent or nature of information to be provided:	
HEALTH SUMMARY (Prior 2 Years)		
PATIENT MEDICAL RECORDS (Dates):		
INPATIENT DISCHARGE SUMMARY (Dates):		
PROGRESS NOTES:		
SPECIFIC CLINICS (Name & Date Range):		
SPECIFIC PROVIDERS (Name & Date Range):		
OPERATIVE/CLINICAL PROCEDURES (Name & Date):		
LAB RESULTS:		
SPECIFIC TESTS (Name & Date):		
DATE RANGE:		
RADIOLOGY REPORTS (Name & Date):		
LIST OF ACTIVE MEDICATIONS:		
VACCINATION (Dose, Lot Number, Date & Location):		
VACCINATION (Dose, Lot Number, Date & Location):		

M

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPI	RIATE, COMPLETE WHEN RE	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s)	below for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnos released even if the boxes are unchecked <u>unless</u> I indica disclosure.			
I do not want sensitive diagnoses released for t other future requests unrelated to this authorization		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has been accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the extent receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after laken to comply with it. are of information carrie	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinion benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
$\square ON (mm/dd/yyyy) \_ (enter a fu)$	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i>	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
VA will provide information upon communication that is required by planning. Information will include mental health, and substance/alcohe developmental, social, financial, CERS officials and as permitted b discharge from GPD. DATE RELEASED RELEASED BY VA FORM	GPD program for ad e but may not be li ol), active medicat and military data,	mission, treat mited to: diag ions and preso as deemed rel	rment, and discharge gnoses (medical, criptions, levant by designated
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

Department of veterans Affairs	RELEASE HEALTH INFORMATION
PRIVACY ACT STATEMENT:	
Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552 requested on this form is voluntary. However, if information needed to locat comply with the request. The Veterans Health Administration may not cond eligibility for benefits on the signing of an authorization, except for research identifiable health information for such research is required. VA may disclos "routine use" disclosure of the information as outlined in the Privacy Act sys	the form authorizes release of information in accordance with the Health Insurance 2a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information te records for release is not furnished completely and accurately, VA will be unable to ition the provision of treatment, payment, enrollment in the VA Health Care Program, or 1-related treatment where an authorization for the use or disclosure of individually- se the information that you put on the form as permitted by law. VA may make a stem of records notices identified as 24VA10A7 "Patient Medical Record - VA", cordance with the Notice of Privacy Practices. VA may also use this information to cords, and for other purposes authorized or required by law.
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location Orlando VAHCS (including all facilities a	
13800 Veterans Way	
Orlando, FL 32827 LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
PATIENT'S MAILING ADDRESS (including City, State and Zip Code	e)
ASPIRE - Orange County 1405 W. Michigan Ave., Orlando, FL 32805 PURPOSE(S) OR NEED: Information is to be used by the requestor	E OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED for: DYMENT OTHER (Please specify below):
INFORMATION REQUESTED: Check applicable box(es) and state the	he extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 Years)	
PATIENT MEDICAL RECORDS (Dates):	
INPATIENT DISCHARGE SUMMARY (Dates):	
PROGRESS NOTES:	
SPECIFIC CLINICS (Name & Date Range):	
SPECIFIC PROVIDERS (Name & Date Range):	
DATE RANGE:	
LAB RESULTS:	
SPECIFIC TESTS (Name & Date):	
DATE RANGE:	
DATE RANGE: RADIOLOGY REPORTS (Name & Date):	
DATE RANGE:	
DATE RANGE:  RADIOLOGY REPORTS (Name & Date):  LIST OF ACTIVE MEDICATIONS:  VACCINATION (Dose, Lot Number, Date & Location):  ADMINISTRATIVE RECORDS:	

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPI	RIATE, COMPLETE WHEN RE	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s)	below for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnos released even if the boxes are unchecked <u>unless</u> I indica disclosure.			
I do not want sensitive diagnoses released for t other future requests unrelated to this authorization		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has been accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the extent receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after laken to comply with it. are of information carrie	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinion benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
$\square ON (mm/dd/yyyy) \_ (enter a fu)$	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE ( <i>if applicable</i>	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
VA will provide information upon communication that is required by planning. Information will include mental health, and substance/alcohe developmental, social, financial, CERS officials and as permitted b discharge from GPD. DATE RELEASED RELEASED BY VA FORM	GPD program for ad e but may not be li ol), active medicat and military data,	mission, treat mited to: diag ions and preso as deemed rei	rment, and discharge gnoses (medical, criptions, levant by designated
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		

PRIVACY ACT STATEMENT:			
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, 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. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually- identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.			
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility) Orlando VAHCS (including all facilities and CBOCS within Orlando VAI 13800 Veterans Way	HCS)		
Orlando, FL 32827			
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)		
PATIENT'S MAILING ADDRESS (including City, State and Zip Code)			
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATIO Family Promise of Greater Orlando (407) 951-8269	N IS TO BE RELEASED		
PURPOSE(S) OR NEED: Information is to be used by the requestor for:			
TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify below):			
<b>INFORMATION REQUESTED:</b> Check applicable box(es) and state the extent or nature of information to be provided by the provided	ed:		
HEALTH SUMMARY (Prior 2 Years)			
PATIENT MEDICAL RECORDS (Dates):			
INPATIENT DISCHARGE SUMMARY (Dates):			
PROGRESS NOTES:			
SPECIFIC CLINICS (Name & Date Range):			
SPECIFIC PROVIDERS (Name & Date Range):			
DATE RANGE:			
OPERATIVE/CLINICAL PROCEDURES (Name & Date):			
LAB RESULTS:			
SPECIFIC TESTS (Name & Date):			
RADIOLOGY REPORTS (Name & Date):			
VACCINATION (Dose, Lot Number, Date & Location):			
OTHER (Describe):			

**RELEASE HEALTH INFORMATION** 

Department of Veterans Affairs

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROP	RIATE. COMPLETE WHEN REI	LEASE IS FOR ANY P	URPOSE
OTHER THAN TREATMENT.			
I request and authorize Department of Veterans Affairs to listed in this authorization.	o release the information pertair	ning to the condition(s) I	pelow for the non-treatment purpose(s)
	HOL ABUSE SICKLE	CELL ANEMIA	
I understand that information on these sensitive diagnose released even if the boxes are unchecked <u>unless</u> I indica disclosure.	es may be released for treatmer ate by checking the box below th	nt purposes without me nat I do not want this inf	checking the above boxes, and will be ormation released for this specific
I do not want sensitive diagnoses released for t other future requests unrelated to this authoriza		specific authorization	n. I realize this does not impact
<b>AUTHORIZATION:</b> I certify that this request has bee accurate and complete to the best of my knowledge. I u authorization in writing, at any time except to the exten receipt by the Release of Information Unit at the facility unauthorized redisclosure, and the information may not	nderstand that I will receive a c t that action has already been ta y housing records. Any disclosu	opy of this form after l ken to comply with it. are of information carri	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinions benefits or, if I receive VA benefits, their amount. They Regional Office that specializes in benefit decisions.			
EXPIRATION: Without my express revocation, the author	prization will automatically expire	e (select one of the follo	owing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
ON (mm/dd/yyyy) (enter a full	ture date other than date signed	l by patient)	
UNDER THE FOLLOWING CONDITION(S):			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable	) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO	PATIENT
TYPE AND EXTENT OF MATERIAL RELEASED	FOR VA USE ONLY		
<pre>VA will provide information upon request via written, verbal, and secured electronic communication that is required by GPD program for admission, treatment, and discharge planning. Information will include but may not be limited to: diagnoses (medical, mental health, and substance/alcohol), active medications and prescriptions, developmental, social, financial, and military data, as deemed relevant by designated CERS officials and as permitted by authorization. The authorization will expire upon discharge from GPD.</pre> DATE RELEASED RELEASED BY VA FORM			
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:		