Clear Form Print Form

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 Zip Code
Date of Birth

Veteran being referred to:

- ☐ Low Demand
- ☐ Bridge Housing
- ☐ Clinical Treatment
- ☐ Service Intensive
- ☐ Transition-In-Place - **FAMILIES ONLY**

(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

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	☐ **VTF (SI, BH)** *Send referrals to:* Fax: (321) 409-8168; e-mail: vtfdirectormelbourne@gmail.com	☐ **Bridges (SI)** *Send referrals to:* Fax: (321) 752-3218 e-mail: jgould@mybridges.org ***Male Only Site***	☐ **Aspire-Brevard (SI, BH)** *Send referrals to:* Chelsea.Adkins@aspirehp.org P: (407) 875-3700 ext 4924 Fax: (321) 504-2028 ***Female Only Site***	☐ **VOA (SI, CT, BH)** *Send referrals to:* Fax: (321) 806-3056 e-mail: ptilbanie@voa-fla.org

☐ **Transition House-Osceola (CT)** *Send referrals to:* Fax: (321) 805-3284 e-mail: lshiflett@thetransitionhouse.org donna@thetransitionhouse.org ***Male Only Site***	☐ **Halifax Urban Ministries-Volusia (LD)** *Send referrals to:* pamela.kyer@va.gov For referral follow-up: BrandyC@halifaxurbanministries.org; p: (386) 252-9400 ext 10	☐ **ASPIRE-Orlando (SI, LD)** *Send referrals to:* Fax: (407) 667-1619 For referral follow-up: Phillip.McCormick@aspirehp.org ***Male Only Site***	☐ **Family Promise (TIP)** Email referrals to: cberg@familypromiseorlando.org ***Families Only***

Referring Agency: Referring Staff Name:	Referring Staff Contact Information:
Veteran Name:	SS#:
Address:	Zip:
Phone:	D.O.B:
Is Veteran Eligible for Medical Care at the VA? ☐ Yes ☐ No ☐ Uncertain	
How many prior GPD (VA Transitional Housing) stays does the Veteran Report?	
Are there legal housing restrictions? ☐ Yes ☐ No ☐ Uncertain	
Identified Gender:	
Marital Status:	# of Children in Custody:
Current Income/Sources:	
Describe current living situation, including if homeless and briefly explain need for housing and support services:	

Mental Health Diagnosis/Substance Use Related Issues?:			
Can the Veteran manage his/her ADLs (bathing, dressing)? ☐ Yes ☐ No			
List any medical equipment or mobility needs. Does Veteran have any medications that require refrigeration? ☐ Yes ☐ No			
Does Veteran have a 30 day supply of current medications?	☐ Yes ☐ No	Are any of the medications controlled substances (opiates, benzodiazepines, methamphetamines, etc)?	☐ Yes ☐ No
Is the Veteran prescribed any medication assisted therapeutics (Methadone, Suboxone, Subutex, etc)?			☐ Yes ☐ No
If known, please list any pending/upcoming medical/mental health appointments and/or consults:			
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)*

321- 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 Pamela.Kyer@va.gov

Nancy Burden – *VOA*

321-637-3788 x43791 Nancy.Burden@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 Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*
Orlando VAHCS (including all facilities and 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 OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Aspire Health Partners
3905 Grissom Parkway Cocoa, Florida 32926

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ 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 *(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)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ 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 APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

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☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed 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

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

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.

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

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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 OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Transition House
3800 5th Street, St. Cloud, FL 34769

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ 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)*: _____

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☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
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- ☐ 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)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

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PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
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PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

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NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Halifax Urban Ministries-Volusia
605 N Segrave St., Daytona Beach, FL 32114

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

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☐ LIST OF ACTIVE MEDICATIONS:
☐ VACCINATION *(Dose, Lot Number, Date & Location)*:
☐ ADMINISTRATIVE RECORDS:
☐ OTHER *(Describe)*:

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
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Department of Veterans Affairs

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NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Vietnam (and all)Veterans of Brevard
700 E. Fee Avenue, Melbourne, FL 32901

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

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☐ 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: _____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed 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

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

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.

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:

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 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 OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Volunteers of America
906 Peachtree St, Cocoa, FL 32922

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ 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 *(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)*:
  ☐ DATE RANGE:
☐ RADIOLOGY REPORTS *(Name & Date)*:
☐ LIST OF ACTIVE MEDICATIONS:
☐ 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 APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

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EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed 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

FOR VA USE ONLY

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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:

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Orlando VAHCS (including all facilities and 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 OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Patriot House, BRIDGES
2452 St. Swithin Ln, Melbourne, FL 32935

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ 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 *(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)*:
  ☐ DATE RANGE:
☐ RADIOLOGY REPORTS *(Name & Date)*:
☐ LIST OF ACTIVE MEDICATIONS:
☐ 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 APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

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☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

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☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

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_____

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

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TYPE AND EXTENT OF MATERIAL RELEASED

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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:

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Orlando VAHCS (including all facilities and 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 OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Housing for Homeless
417 Rockpit Rd. Suite 105, Titusville, FL 32796

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ 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 *(Dates)*:
☐ PROGRESS NOTES:
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  ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
  ☐ 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)*:
☐ ADMINISTRATIVE RECORDS:
☐ OTHER *(Describe)*:

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

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☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

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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

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TYPE AND EXTENT OF MATERIAL RELEASED

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VA FORM

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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Orlando VAHCS (including all facilities and 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 OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
ASPIRE - Orange County
1405 W. Michigan Ave., Orlando, FL 32805

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

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  ☐ SPECIFIC CLINICS *(Name & Date Range)*:
  ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
  ☐ 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)*:
☐ ADMINISTRATIVE RECORDS:
☐ OTHER *(Describe)*:

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

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☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

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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

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VA FORM

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Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

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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 INFORMATION IS TO BE RELEASED
Family Promise of Greater Orlando
(407) 951-8269

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ 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)*

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☐ 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)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

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PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
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PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

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DATE RELEASED
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VA FORM

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