Items to Complete on VA ROI Form:

1. Patient Name, Last 4 Social Security No, Date of Birth – On BOTH Pages
2. Initial the (2) Boxes under heading: VETERAN'S REQUEST
    a. Drug Abuse
    b. Alcoholism or Alcohol Abuse
3. Signature of patient and Date on Page 2

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. 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 the information including the last four of your Social Security Number (SSN) and Date of Birth (used 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 treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

Central Texas VA Health Care System
1901 Veterans Memorial Dr
Temple, Texas

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Hays County Veterans Treatment Court (712 S Stagecoach Trail, San Marcos, TX, 78666), all affiliated individuals, agencies, attorneys, and court evaluator

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ SICKLE CELL ANEMIA

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

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

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ 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: all drug tox screens past and future as deemed relevant by the court

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

☒ LIST OF ACTIVE MEDICATIONS _____

☒ OTHER *(Describe)*: eligibility for VA services, past/current diagnosis(es), treatment, medications, attendance/participation in therapy/groups, appts, lab/drug screen results

PURPOSE(S) OR NEED

Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ OTHER *(Specify below)*

_____

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

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.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): authorization expires upon the discharge of Veteran from the Hays County Veterans Treatment Court or not to exceed 3 years

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

DATE RELEASED	RELEASED BY:

HAYS COUNTY VETERANS TREATMENT COURT
County Court at Law, No 2
712 S. Stagecoach Trl. #2292
San Marcos, TX 78666
512-878-6677

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION TO THE VETERANS ADMINISTRATION

1. I, _____ authorize
(Participant Name)

Hays County Veterans Treatment Court Program staff

to disclose to: **the Veterans Administration** the following information:

a. My status in the Veterans Treatment Court

b. Known or disclosed history of substance abuse

c. My arrest history

d. Assessment results relevant to my treatment with the VA

2. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

3. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent **expires automatically** as follows:

Upon completion of, or release from the Veterans Treatment Court Program.
(One year from date below unless otherwise specified)

Date: _____ _____
Signature of Client

_____
VTC Staff Signature

HAYS COUNTY VETERANS TREATMENT COURT
County Court at Law, No 2
712 S. Stagecoach Trl. #2292
San Marcos, TX 78666
512-878-6677

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION TO THE TREATMENT COURT TEAM AND PROVIDERS

1. I understand that the Veterans Treatment Court is a treatment court and in accordance with standard practice, information about me will be shared among various members of the treatment court team.

2. Information is shared both by email and verbally, both before and during pre-court staffing. Information shared may include psychological and substance abuse assessments, participation in court-ordered treatment, urinalysis results and other information relevant to my compliance with Veterans Court requirements.

3. The purpose of sharing information is to assist all members of the team in developing a clear and accurate understanding of my treatment and legal needs, as well as my progress toward meeting requirements of the Court.

4. I, _____ authorize

Hays County Veterans Treatment Court staff

to disclose information described above to staff members representing the: Veterans Administration, District Attorney's Office, Adult Probation Office, Pretrial Services, Austin Veterans Center, and appropriate community treatment providers (such as Hill Country, Grace After Fire, Hope for Heroes Program, Austin Recovery, and others).

5. I understand that any records related to substance abuse and treatment are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my signing this written consent unless otherwise provided for in the regulations. I also understand this consent expires automatically 90 days after my discharge from the Veterans Treatment Court program.

Date: _____ _____
Signature of Client

_____
VTC Staff Signature

HAYS COUNTY VETERANS TREATMENT COURT
County Court at Law, No 2
712 S. Stagecoach Trl. #2292
San Marcos, TX 78666
512-878-6677

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION TO DEPARTMENT OF DEFENSE TREATMENT PROVIDERS

(For Active Duty only)

1. I, _____ authorize
(Participant Name)

Hays County Veterans Treatment Court (VTC) Program staff

on a need to know basis only, to disclose to and consult with: behavioral health, substance abuse, and other Department of Defense treatment providers and contractors, the following information for the purpose of verifying the completion of VTC program requirements:

a. My status in the Veterans Treatment Court

b. Known or disclosed history of substance abuse

c. My arrest history

d. Assessment results relevant to my treatment with these providers

2. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

3. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent **expires automatically** as follows:

Upon completion of, or release from the Veterans Treatment Court.
(One year from date below unless otherwise specified)

Date: _____ _____
Signature of Client

_____
VTC Staff Signature