



Authorization for the Use or Disclosure Of Protected Health Information



As required by the Health Insurance Portability and Accountability Act of 1996, as amended, the South Dakota Department of Veteran’s Affairs may not use or disclose your personally identifiable health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to the Department.

Section 1: (Veteran Information)

I,

Veteran Name:

Claimant’s Name (if other then the veteran):

Address:

City: State: Zip Code:

Date of Birth:

Phone #:

hereby authorize the Department of Veteran’s Affairs to release the information described in Section 2 of this Authorization, to the persons, entities or classes of persons or entities listed in Section 3 of this Authorization.

Section 2: Information Requested

Specific information requested: All information related to eligibility for veteran’ services including all health and financial information.

Specific dates of service for the information requested: All dates of service relevant to the eligibility determination.

Purpose of the disclosure: Facilitating eligibility determinations for veteran’s services.

Section 3: Recipient Information

The specified information is to be released to the following persons, entities or classes of persons or entities:
All county veteran’s services officers (CVSO) and tribal veteran’s services officers (TVSO).

Section 4: Disclosures

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. The South Dakota Department of Veterans Affairs, its employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in the Department's Notice of Privacy Policies, this consent form may be revoked at any time except to the extent the staff has taken action upon it. If not revoked, this Authorization to release protected health information will terminate in **five years** or upon the following specified date . I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol treatment information, HIV testing information, and mental health treatment information may not be re-disclosed without my specific consent.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Veteran's Affairs or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify.

Section 5: Signatures

Signature of participant/patient, parent, guardian, or authorized representative giving consent

Date

Print Name

Relationship to Participant/Patient

If signed by a personal representative, provide a description of the representative's authority to act for the participant/patient.

Telephone number of the participant/patient, parent, guardian, or authorized representative for verification of the request for information

REVOCATION OF AUTHORIZATION

I hereby cancel this request to release information effective immediately:

Signature

Date