Department of Veterans Affairs

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO STATE/LOCAL PUBLIC HEALTH AUTHORITIES

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, (HIPAA) 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701. Your disclosure of the information requested on this form, including Social Security Number (SSN) is voluntary. However, if the information, including SSN (the SSN will be used to locate records for release) is not furnished completely and accurately, the Veterans Health Administration (VHA) will be unable to report to public health authorities. VHA may not condition treatment, payment, enrollment or eligibility to VA benefits on your signing the authorization. VHA 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 systems of records notices identified as 24VA10A7, "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices.

Patient Full Name (please print):

Last: ______________________ **First:** ______________________ **Middle:** ______________________

Birth Date (mm/dd/yyyy): ______________ **LAST 4 SSN:** ________

Requestor Name: State and Local Public Health Authorities

Information Requested:
Immunization records from the electronic health record, including those created after date of signature.

I request and authorize my VA health care facility to release my health information related to immunizations for public health purposes to State and Local Public Health Authorities when reporting is desired by the State.This authorization covers the immunization records that exists upon signing of the authorization and immunization records that may be created in the future. Treatment, including providing immunizations, payment, enrollment, or eligibility for benefits cannot be conditioned upon the completion of this authorization.

This authorization will remain in effect for the period of ten (10) years. 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 my VA health care facility. Redisclosure of my electronic health records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected.

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.

______________________________ ______________
Signature of Patient **Date**