Authorization to Disclose
Claimant/Benefit and Protected Health Information

The 5th Judicial District Veterans Program has made it a condition of my participation in its disposition of my pending criminal matters that I disclose information protected by 5 U.S.C. 552a, 38 U.S.C. 5701, 45 CFR Parts 160 and 164, and 38 USC §7332 (drug and alcohol abuse, HIV infection, and sickle cell anemia) to the criminal justice system.

Therefore, I, _____, request that the United States department of

(Veteran's Name)

Veterans Affairs, Veterans Benefits Administration, and Veterans Health Administration disclose my claimant and/or benefit information and protected health information to the following:

The 5th Judicial District Veterans Court Program including contracted third-party agent_____ Minnesota Assistance Council for Veterans (MACV) and all parties sanctioned by and associated with its Veterans Program in either pre or post court proceedings. _____ _____ _____

I authorize release of the following protected health information:

Any and/or all claimant and/or benefit information and any and/or all medical and psychological information to include communication in person, by telephone, mail, encrypted email, or fax.

I certify that this request is made freely, voluntarily and without coercion and that the information on this form 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 understand that the VA may not condition treatment, payment, enrollment, or eligibility for benefits upon my signing of this authorization.

This authorization, will expire upon discharge from the 5th Judicial District Veterans Program. I understand that I may not revoke this authorization before that date. I understand that failure to provide the Veterans Program with the appropriate authorizations may lead to my removal from the Veterans Program venue and the transfer of my pending criminal matters to the regular District Court venue.

_____ _____

Date Print Name and Last Four of SSN

_____

Signature

_____

Address