ORANGE COUNTY PROBLEM SOLVING COURT REFERRAL FORM Adult Drug Court: Suite 325, P: (407) 836-0419, F: (407) 836-0528 Email: <u>drugctreferral@ocnjcc.org</u> Veterans Treatment Court: Suite 510 P: (407) 836-0651 Email: <u>veteranscourt@ocnjcc.org</u> Mental Health Court: Suite 510 P: (407) 836-0578 Email: <u>ctdclv1@ocnjcc.org</u>					
DATE: DIV Program: ADC VTC MHC					
REFERRAL TYPE: (Track I) Diversion (Track II) Post Plea (Track III) VOP Transfer IN / OUT					
REFERRED BY:         Public Defender         Private Counsel         Judiciary         State Attorney         Other					
Defense Attorney Name: Phone: ()					
Assistant State Attorney Name:					
CLIENT INFORMATION:					
Name:,,,					
Last First Middle Initial					
A/K/A:					
Street Address (please indicate if the defendant is homeless):					
City: State: Zip Code:					
Race: B/W/Other: Gender: Male / Female DOB://					
Primary Phone #: () Secondary Phone #: ()					
SSN:					
Has the defendant ever served in the United States Armed Forces? Yes / No					
Is the defendant currently in jail? Yes / No					
CASE INFORMATION:					
Case No.:					
Charge(s):					
Notes:					
DO NOT WRITE BELOW THIS SECTION (PROBLEM SOLVING COURT OFFICIAL USE ONLY)					
CRIMINAL HISTORY CHECK: VERIFIED BY: NOTES:					
STATE ATTRORNEY'S OFFICE REVIEW:         SAO Reviewed for: DIVERSION POST PLEA VIOLATION OF PROBATION         SAO review: APPROVED / DENIED or INCOMPLETE Sentencing Score:         SAO Comments:					
PROBLEM SOLVING COURT PROGRAM OFFICE FINAL REVIEW: PSCPO Review: APPROVED DENIED/ REASON:					

First At and Paperveck, Reduction Act Information. The exceeds on if this from above 3 with prevalence of the lange and the prevalence	$\mathfrak{A}$	Departmer	nt of Veterans Affairs		QUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION			
TO DEPARTMENT OF VETERANS APPARS (Print or type name and address of healt Core facility  EXTENT NAME is an Event Mode (mag)  EXCEL SECURITY NAME is  EXCELSED  EXCELSES OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELSES OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELSES OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELSES OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  EXCELS AND INFORMATION IS	informal CFR Pai includin comply that you Medical request Number purpose section number.	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, 4 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable t 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patier Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process you request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Securit Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for othe purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information of information unless it displays a valid OMI number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather th						
Care facility								
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED         VETTERAN'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 regaring the following condition(s):         DBUG ABUSE       ALCONLOW RA ALCONG ABUSE       TENDS FOR ON INFORMATION MINIMODEFICIENCY VIEW INFORMATION INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each         INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each         PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED         NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         AUTHORIZATION: I. Certify that this request has been made freely, voluntarily and without corecrisin and 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, have voke the authorization. The written authorization and may no longer be protected. Without my tarber written authorization and may no longer be protected. Without my express revocation, the authorization and may no longer be protected. Without my express revocation, the authorization of the need for disclosure (2) on			AFFAIRS (Print or type name and address of healt		Initial)			
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):         DUG ABUSE       ALCOHOLISM OF ALCOHOL ABUSE       TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HV)       SICKLE CELL ANEMIA         INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)       OTHER (Seech)         PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED       OTHER (Seech)         PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED       OTHER (Seech)         AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and fore of this form atter 1 sign it. 1 may revoke this authorization, the extent or matter of this form atter 1 sign it. 1 may revoke this authorization, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on								
Individual named of his request. I understand that the information to be released includes information regarding the following condition(s):       Information regarding the following condition(s):         INFORMATION REQUESTED (Check applicable box(cs) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)       Information to be disclosed, giving the dates or approximate dates covered by each)         COPY OF HOSPITAL SUMMARY       COPY OF OUTPATIENT TREATMENT NOTE(s)       OTHER (speedy)         PURPOSE(s) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED       NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coverion 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 1 sign i. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Writher revocation is effective upon receipt by the Release of Information Unais the receiver State Math I will receive a copy of this form after 1 sign i. I may revoke this authorization and may no longer be protected. Without my express revocation, the authorization and may no longer be protected. Without my express revocation, the authorization is condition(s):         I understand that the VA health care practitioner'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 Reg	NAME AN	D ADDRESS OF ORGAN	ZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL	TO WHOM INFORMATION IS TO BE RELEAS	SED			
approximate dates covered by each       COPY OF OUTPATIENT TREATMENT NOTE(S)       OTHER (Speedy)         PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED         NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         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. Lunderstand that I will receive a copy of this form after 1 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. Writen revocation is effective upon crecipit by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorization and may be accomplished without my further writen authorization and may cancer by by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on	individ	ual named on this re	equest. I understand that the information	on to be released includes information	tion regarding the following condition(s):			
NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):         I understand that the VA health care practitioner'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.         DATE (mm/ddiyyyy)       SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)		mate dates covered	by each)					
NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):         I understand that the VA health care practitioner'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.         DATE (mm/ddiyyyy)       SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)								
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 the records. Redisclosure of my medical records by those receiving the above authorized information will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on(date supplied by patient); (3) under the following condition(s):  I understand that the VA health care practitioner'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.  DATE (mm/dd/yyyy)  SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)  FOR VA USE ONLY  MPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)  Type AND EXTENT OF MATERIAL RELEASED	PURPOS	E(S) OR NEED FOR WHI	H THE INFORMATION IS TO BE USED BY INDIV	IDUAL TO WHOM INFORMATION IS TO BE I	RELEASED			
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 the records. Redisclosure of my medical records by those receiving the above authorized information will be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):  I understand that the VA health care practitioner'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.  DATE (mm/dd/yyyy) SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)  FOR VA USE ONLY  MPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)  Type AND EXTENT OF MATERIAL RELEASED		NOTE:	ADDITIONAL ITEMS OF INFORMA	TION DESIRED MAY BE LISTED	ON THE BACK OF THIS FORM			
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.         DATE (mm/dd/yyyy)       SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)         FOR VA USE ONLY         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)       TYPE AND EXTENT OF MATERIAL RELEASED	accura in writ Releas inform author	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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3)						
FOR VA USE ONLY         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)         TYPE AND EXTENT OF MATERIAL RELEASED	other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are							
IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number) TYPE AND EXTENT OF MATERIAL RELEASED	DATE (r	nm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHO	ORIZED TO SIGN FOR PATIENT (Attach auth	ority to sign, e.g., POA)			
				FOR VA USE ONLY				
DATE RELEASED BY	IMPRINT	PATIENT DATA CARD (c	r enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIA	L RELEASED			
				DATE RELEASED	RELEASED BY			

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):         Image: DRUG ABUSE       Image: ALCOHOLISM OR ALCOHOL ABUSE       Image: TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)       Image: SICKLE CELL ANEMIA         INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or       Image: Sickle Cell Anemia	Department of Veterans Affairs		HORIZATION TO RELEAR R HEALTH INFORMATIO						
TO_DEFAULTION OF VETERANS AFFARS (Print or type name and address of health in the health or health)       PATEENT NAME [Last, Flax, Mudde Insail]         SIGUAL_SECURITY NUMBER       SIGUAL_SECURITY NUMBER         Orlando, FL_32827       SIGUAL_SECURITY NUMBER         MARE ARE ADDRESS OF DERANQUATION. INDIVIDUAL OF ITLE OF INDIVIDUAL TO VHOM INFORMATION IS TO BE RELEASED         Guests of Orange County Veterans Treatment OV veterans Affairs to release the information specified below to the organization, or individual name on this request. Individual name on this request. Individual name on the information specified below to the organization, or individual name on this request. Individual name on the information specified below to the organization, or individual name on this request. Individual name or be released in the information to be disclosed, giving the dates or approximate disc scorered by each)         Drug Drug ABUSE       ALCOHOLISMOR ALCOHOL ASUSE       TEETING FOR OR INFECTION WITH HUMAN BIANACCEPTICIENCY VIRUS (HW)       GOLD CLI ANEMAR         NINFORMATION REQUESTED Check applicable box(s) and state the extent or nature of the information to be disclosed, giving the dates or approximate diase covered by each)       GOLD OF OUTPATIENT INCE(S)       OTHER (Speedy)         All medical records and health information, past and future, related to court-directed treatment         PURPOSE(S) OR NEED FON WHOLT WE INFORMATION IS TO BE USED BY NAME NET ELESTED ON THE BACK OF THIS FORM         AUTHORIZATION: Tecrify that his request has been made frequely, volunting in an advex is accontake and complete to the best of my knowledge. Tunderstand that	<b>Privacy Act and Paperwork Reduction Act Information:</b> 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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 as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. 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. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will avera								
Chando VA Medical Center 13800 Veterans Way Orlando, FL 32827 Social, SECURITY NUMBER SOCIAL, SECURITY, S	ENTER BELOW THE PATIENT'S NAME AND SOCIAL SE	ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.							
13800 Veterans Way       SOCIAL SECURITY NUMBER         Orlando, FL 32827       SOCIAL SECURITY NUMBER         Social Security Number       Social Security Number         Build And State Machines Social Control (OCVTC) not directly involved with court-directed treatment       Social Security Number         VetTERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information regarding the following condition(s):       Social Security Number         Imply and Abuse       ALCONCLASMOR ALCONC ABUSE       TETMO FOR ON INFECTION WITH HUMAN INMUNCEPTICENCY VITUS (MI)       Social Security Number         Imply and Abuse       ALCONCLASMOR ALCONC ABUSE       TETMO FOR ON INFECTION WITH HUMAN INMUNCEPTICENCY VITUS (MI)       Social Security Number         Imply and Abuse       ALCONCLASMOR ALCONC ABUSE       TETMO FOR ON INFECTION WITH HUMAN INMUNCEPTICENCY VITUS (MI)       Social Security Number         Imply and Abuse       ALCONCLASMOR ALCONC ABUSE       TETMO FOR ON INFECTION WITH HUMAN INMUNCEPTICENCY VITUS (MI)       Social Security Number         Imply and Abuse       Imply and Abuse       Imply and the social Security Number       Social Security Number         Imply and Abuse       Imply and Abuse       Imply and the social Security Number       Social Security Number         All medical records and health information, past and future, related to court-directed treatment       PUPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY NOVIOUAL TO WHOM IN		PATIENT NAME (Last, First, Middle	Initial)						
Guests of Orange County Veterans Treatment Court (OCVTC) not directly involved with court-directed treatment         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. Indicated that the information to be released includes information regarding the following condition(s):         Image: Imag	13800 Veterans Way Orlando, FL 32827		SOCIAL SECURITY NUMBER						
treatment         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): <ul> <li>DIVUG AUSE</li> <li>ALCOHOLEM OR ALCOHOL AGUEST</li> <li>DIVUG AUSE</li> <li>ISTING FOR OR INFECTION WITH HUMAN MAUNQUEFICIENCY VIRUS (HW)</li> <li>SCRLE CELL ANEMA</li> </ul> INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)       ISTING FOR ON UNITED (The CARD proceed)         All medical records and health information, past and future, related to court-directed treatment         PURPOSEES; OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED         To provide OCVTC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests OCVTC         NOTE: ADDITIONAL TEMS OF INFORMATION DESIRED MAY BE LISTED ON THE ACK OF THIS FORM         AUTHORIZATION: I certify that this request has been made freely, volutarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. Lunderstand that I will receive a copy of this form after I sign it. I may revoke this authorization, within a writing, an writing and writin									
Individual named on this request. I understand that the information to be released includes information regarding the following condition(s):           Image: The ALCOHOLISM OR ALCOHOLABUSE         Image: The STING FOR OR INFECTION WITH HUMAN IMMUNOPERCENCY VIRUS (W))         SCRUE CELL ANEMAL           INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)         Image: The Covered by each)         Image: The Covered by each)           Image: The Covered by each         Image: Covered by each)         Image: Covered by each         Image: Covered by each)           All medical records and health information, past and future, related to court-directed treatment         PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY NOWIDUAL TO WHOM INFORMATION IS TO BE RELEASED           To provide CCVTC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests OCVTC           NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM           AUTHORIZATION: Icertify that this request has been made freely, voluntarily and without covercion and that the information given above is accurate and complete to the best of my knousing the records. Redisclosure; (2) on	Guests of Orange County Veterans Treatment treatment	Court (OCVTC) not di	rectly involved with co	urt-directed					
approximate dates covered by each)       Image: COPY OF OUTPATIENT TREATMENT NOTE(S)       Image: OTHER (Specify)         All medical records and health information, past and future, related to court-directed treatment         PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED         To provide OCVTC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests OCVTC         NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         AUTHORIZATION: 1 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. Lunderstand that I will receive a copy of this form after 1 sign it. I may revoke this authorization is any time exceeding the activity in the author atken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorization may be accomplished without to string authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on	individual named on this request. I understand that the information	to be released includes information	tion regarding the following con	ndition(s):					
All medical records and health information, past and future, related to court-directed treatment PURPOSE(5) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED TO provide OCVTC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests OCVTC NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM 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 1 sign it. I may revoke this authorization, in writing, a day time except to the extent has accomplished without my characterize taken to comply with it. Written revocation is effective upon receiping by the information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization of court-related/legal issues Upon resolution of court-related/legal issues DATE (mm/dd/yyyy) SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) FOR VA USE ONLY MERNIT PATIENT DATA CARD (or enter Name, Address, Bodial Security Number)	approximate dates covered by each)			g the dates or					
PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED TO provide OCVTC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests OCVTC NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM 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 actinity housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s): Upon resolution of court-related/legal issues I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefit, 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. DATE (mm/dd/yyyy) INFINIT DATA CARD (or enter Name, Address, Social Security Number) IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number) IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)									
To provide OCVTC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests OCVTC         NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         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 receive for may be accomplished without my further written authorization and may no longer be protected. Without my serpess revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on	All medical records and health information, pa	ast and future, related	to court-directed trea	tment					
signature of this authorization and to provide training to the guests OCVTC         NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM         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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):         Upon resolution of court-related/legal issues         DATE (mm/dd/yyyy)       SiGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)         TYPE AND EXTENT OF MATERIAL RELEASED       TYPE AND EXTENT OF MATERIAL RELEASED									
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 the records. Redisclosure of my medical records by those receiving the above authorized information will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):         Upon resolution of court-related/legal issues         I understand that the VA health care practitioner'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.         DATE (mm/dd/yyyy)       SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)         TYPE AND EXTENT OF MATERIAL RELEASED         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	•	•		er the					
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 the records. Redisclosure of my medical records by those receiving the above authorization information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s): Upon resolution of court-related/legal issues Upon resolution of court-related/legal issues DATE (mm/dd/yyyy) SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) FOR VA USE ONLY IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	NOTE: ADDITIONAL ITEMS OF INFORMATI	ON DESIRED MAY BE LISTED	O ON THE BACK OF THIS FOR	M					
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.         DATE (mm/dd/yyyy)       SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)         FOR VA USE ONLY         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)       TYPE AND EXTENT OF MATERIAL RELEASED	accurate and complete to the best of my knowledge. I understand in writing, at any time except to the extent that action has already Release of Information Unit at the facility housing the records. Re information may be accomplished without my further written auth authorization will automatically expire: (1) upon satisfaction of the under the following condition(s):	that I will receive a copy of this been taken to comply with it. W disclosure of my medical recor- orization and may no longer be	s form after I sign it. I may revo /ritten revocation is effective up ds by those receiving the above protected. Without my express	ke this authorization, on receipt by the authorized revocation, the					
FOR VA USE ONLY         IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)       TYPE AND EXTENT OF MATERIAL RELEASED	other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are								
IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)       TYPE AND EXTENT OF MATERIAL RELEASED	DATE (mm/dd/yyyy) SIGNATURE OF PATIENT OR PERSON AUTHORI	ZED TO SIGN FOR PATIENT (Attach auth	nority to sign, e.g., POA)						
	FOR VA USE ONLY								
DATE RELEASED BY	IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIA	L RELEASED						
		DATE RELEASED	RELEASED BY						

Standard Form 180 (Rev. 11/2015) (Page 1) Prescribed by NARA (36 CFR 1233.18 (d)) Authorized for local reproduction Previous edition unusable

## **REQUEST PERTAINING TO MILITARY RECORDS**

	veterans or deceased veteran's next-of-kin may be sub- best possible service, please thoroughly review the accom-					
	<b>SECTION I - INFORMATION NEEDED</b>	TO LOCA	<b>FE RECORDS</b>	(Furnish a	s much info	ormation as possible.)
1. NAME USI	ED DURING SERVICE (last, first, full middle)		SECURITY #			4. PLACE OF BIRTH
5. SERVICE.	PAST AND PRESENT (For an effective records searc	h it is importa	nt that ALL service	he shown hel	ow)	
	BRANCH OF SERVICE	DATE ENTERED	DATE		ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	-					
b. RESERVE	-					
c. STATE NATIONAL GUARD	-					
	CRSON DECEASED?  NO  YES - <i>M</i> PERSON <u>RETIRE</u> FROM MILITARY SERVICE?		Date of Death if ve	eteran is dece	eased:	
	SECTION II – INFORMA		D/OR DOCUM	IENTS RE	OUESTE	a
DD Form This form persons of	<b>HE ITEM(S) YOU ARE REQUESTING:</b> <b>214 or equivalent.</b> Year(s) in which form(s) issued t contains information normally needed to verify milita r organizations, if authorized in Section III, below. An DELETED copy, the following items will be blacked of	ry service. A c	copy may be sent t ED DD214 is ordin	narily requi	red to deter	mine eligibility for benefits. If you
(SPD/SPN An UNDI	N) code, and, for separations after June 30, 1979, chara ELETED copy will be sent UNLESS YOU SPECIFY.	cter of separat A DELETED	tion and dates of the COPY by checking	me lost. ag this box:	I want a	DELETED copy.
	<b>Records</b> Includes Service Treatment Records, Health ( onth and year) for EACH admission <b>MUST</b> be provide		d Dental Records.			
result in a faste	(Providing information about the purpose of the requ r reply. Information provided will in no way be used to (explain) Employment VA Loan Progra	est is <b>strictly</b> o make a decis	voluntary; howev sion to deny the re-	quest.)		e the best possible response and may <ul> <li>Personal</li> <li>Other (explain)</li> </ul>
	SECTION III - R	ETURN AI	DDRESS AND	SIGNATU	RE	
1. REQUEST	ER NAME:					
I, above I, above I am the	e MILITARY SERVICE MEMBER OR VETERAN identified e. e DECEASED VETERAN'S NEXT-OF-KIN ( <i>MUST submit</i> See item 2a on instruction sheet.)		I am the VETE Appointment, Authorization OTHER	) or AUTHOR	IZED REPRES	SENTATIVE (MUST submit copy of
	(Relationship to deceased veteran) FORMATION/DOCUMENTS TO: or type. See item 4 on accompanying instructions.)	s	tate) under penal	ty of perjury	ATURE: I d y under the	pe of Other) declare (or certify, verify, or laws of the United States of
ORANGE C	OUNTY VETERANS COURT OFFICE					ion III is true and correct and ed information. (See items 2a or
Name 425 N. O	RANGE AVE	3	a on accompanyin of the veteran, next	ng instruction of-kin of dec	sheet. With ceased veter	out the Authorization Signature an, veteran's legal guardian, orized representative, only
Street ORLANDO	FL 3280	Apt. I	limited information can be released unless the request is archival. No signature is required if the request if for archival records. )			
City	State Zip Coo	de				
* This form is a	available at <i>http://www.archives.gov/veterans/military-ser</i> ard-form-180.html on the National Archives and		Signature Requir (407) 836-0		print	Date (407) 835-5074
	istration (NARA) web site. *		Daytime phone eteranscou	rt@ocnjo	cc.org	Fax Number

Email address