Authorization for Release of Confidential Information

Deceased Veteran's Full Name: _____

Date of Birth (mm/dd/yyyy): _____ Date of Death (mm/dd/yyyy): _____

I, _____, authorize the release of information to the _____ Suicide Mortality Review Committee for the purpose of conducting a quality assurance review regarding my deceased family member.

Organizations to Whom Information is to be Released: Below is a list of Suicide Mortality Review Committee organizations who may have had contact with your family member. Even if you have reason to believe your family member did not have any contact with these organizations, we will not be able to request or disclose information without your signature. By signing below, I authorize the following organizations to disclose and share information with each other during the review process. Any information obtained in this process will be confidential to the members of the committee.

- County Departments and Programs
- County District Attorney's Office
- State of _____ Department of Human Services Departments and Programs
- Law Enforcement (Federal, State, Local) Departments and Programs
- Veterans Affairs (VA)/ Veterans Health Administration (VHA)
- Healthcare Representatives (Hospitals, Providers, Coordinated Care Organizations)
- Mental Health Representatives (Hospitals, Providers, Coordinated Care Organizations, National Organizations, Including the National Alliance on Mental Illness)
- Local and National Crisis Line Representatives
- Faith Community Representatives
- Education, School District, College/University Representatives

Name and Address of Organization To Whom Information Is To Be Released

_____

_____

Information Requested: The information requested by the _____ Suicide Mortality Review Committee on the decedent is:

☐ All health information from _____ to _____ prior to the date of death, including drug abuse, alcoholism or alcohol abuse records, sickle cell anemia, human immunodeficiency virus (HIV) in the possession of the organizations listed below who participate on the Suicide Mortality Review Committee.

☐ Other information (Describe): _____

_____

_____

De-identified or anonymized information will be used for an annual report _____.

Authorization: I may refuse to sign this authorization. My refusal to sign this authorization will not impact my treatment, payment, enrollment, or eligibility for benefits.

I may inspect or copy any information used and/or disclosed under this authorization. My authorization may be revoked at any time in writing; the only exception is when the action/disclosure has already occurred as instructed in the authorization. Written revocation is effective upon receipt by the Release of Information department at the organization or facility housing the records. This authorization will expire one (1) year after the date of signature. I understand that information may be released to an entity not covered by Federal privacy laws or regulations and redisclosed.

A copy of this form shall have the same validity as the original. I understand that I will receive a copy of this form after I sign it.

Legal Representative/Personal Representative Signature _____

Date (mm/dd/yyyy): _____ Relationship to Deceased: _____