General Release of Information

Revised 1/05/2016

Date: _____

Name: _____ DOB:_____ Last 4 of SSN: _____

I authorize the release of all records to and from the Veteran Homestead, Inc. (VHI), 69 High St. Fitchburg, MA 01420, and its programs including personal, medical, psych/social, financial, VAMC, police and any other files. Also, I grant full permission to speak to my therapists, counselors, psychologists, case managers, and those involved in my care, during the application process and as long as I am a resident at the of the Veteran Homestead, Inc.

____Yes ____No ____Initial

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results are released to anyone.

____Yes ____No ____Initial

I authorize the release of any records to and from VHI regarding drug, alcohol, or mental health treatment to the person(s) listed above.

____Yes ____No ____Initial

Date: _____

Signature: _____

Witness:_____