**YOU MUST READ, AGREE AND SIGN BELOW**

| THIS BOX TO BE COMPLETED BY THE VCCB<br>**WHOSE *Records to be disclosed:*** | | |
|---|---|---|
| NAME: First | Middle | Last |
| SSN | Birthday (MM/DD/YY) | |

# AUTHORIZATION TO DISCLOSE INFORMATION TO THE VIOLENT CRIMES COMPENSATION BOARD (VCCB)

**** PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW ****

I voluntarily give permission to any hospital, clinic, doctor, mental health treatment provider, employer, law enforcement authority, prosecution authority, agency, or person to exchange needed information with the State of Alaska, Department of Administration, Violent Crimes Compensation Board to determine claim eligibility and request disclosure (including paper, oral and electronic interchange).

This includes specific permission to release all my medical, psychological, education, employment, and other information related to my ability to perform tasks. This specific permission includes permission to release:

1. **All records and other information regarding treatment, hospitalization, and outpatient care for my impairments(s) (if any) *including,* and not limited to:**
   - **Psychological, psychiatric or other mental impairments(s)**
   - **Drug abuse, alcoholism, or other substance abuse.**
   - **Sickle cell anemia**
   - **Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases.**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of psychological evaluations and any other records that can help evaluate function and impact of violent crime.**
4. **All information to determine crime victim compensation claim eligibility past present and future.**

## FROM WHOM

- **All medical and psychological sources** (hospitals, clinics, labs, physicians, psychologists, dentists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/ rehabilitation counselors
- Consulting examiners used by the VCCB
- Other who may know about my condition (family, neighbors, friends, public officials, employers)
- Employers past and present
- Law enforcement, prosecution authorities, and any program including those funded through the Council on Domestic Violence and Sexual Assault

| THIS BOX TO BE COMPLETED BY THE VCCB (**as needed**) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed: |
|---|
| |

## TO WHOM

**The Violent Crimes Compensation Board, and/or Board designee.**

## PURPOSE

To determine my **eligibility for crime victim compensation under Alaskan law AS 18.67**.

## EXPIRES WHEN

I understand this information release is valid from the date of my signature until the claim is closed and that I can cancel this release by writing to the VCCB at any time, except if any information has already been received and used is not subject to cancellation.

- I understand a photocopy of this signed form is as valid as the original, and that my signature gives permission for the release of all information specified in this form.
- I understand that Alaska and Federal Laws require the compensation program to keep any confidential information it receives confidential.
- I understand that all information necessary for use in law enforcement, prosecution, or the collection of restitution may be released to parole, probation, law enforcement or prosecution authorities.
- I understand the information will be used to determine compensation benefits, and only that information needed to make a decision about compensation benefits will be requested by the compensation program.
- **I have read this form and agree to the disclosures above from the sources listed.**

## REPAYMENT AND SUBROGATION AGREEMENT

**(This form must be signed and dated in both places to process this claim)**

I understand that Alaska law requires me to contact the Violent Crimes Compensation Board if I receive payments from the offender, a civil lawsuit, an insurance program, or any other government or private agency. I also understand that I may be required to repay the VCCB. I agree to notify the VCCB if I hire an attorney to represent me in any action related to this crime.

I certify the information in this application is true and correct to the best of my knowledge. I understand that my signature says I agree to all statements in this agreement.

***SIGN*** → _____ Date _____

Applicant Signature (parent or guardian must sign if victim is a minor)

| **INDIVIDUAL** authorizing disclosure<br>***SIGN*** → | **IF not signed by subject of disclosure, specify basis for authority to sign:**<br>☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain) | | |
|---|---|---|---|
| Date Signed: | Street Address: | | |
| Phone Number | City | State | ZIP |

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR Parts 160 and 164 and Alaska Statue 18.67