

Kenneth J. Hopkins
Mayor

Colonel Michael J. Winquist
Chief of Police



"A Nationally Accredited Agency"

FIVE GARFIELD AVENUE
CRANSTON, RHODE ISLAND 02920
Phone (401) 942-2211 TDD 943-1410

RENEWAL APPLICATION INSTRUCTIONS (2025)

LICENSE TO CARRY A CONCEALABLE WEAPON

1. This official application form must be filled out completely by the applicant and **NOTARIZED. PRINT LEGIBLY** or **TYPE** application. This application and submitted documents become property of the Cranston Police Department.
2. **MANDATORY-** Proof of residency must be provided (utility bill, pay stub, operator's license)
3. **MANDATORY-** Proof of a conceal carry course, a basic handgun/pistol training safety course, or a DEM blue card. (**LAW ENFORCEMENT-MILITARY- NRA INSTRUCTOR'S ARE EXEMPT. MUST PROVIDE PROOF**).
4. **MANDATORY-** Proof of a **NOTARIZED** qualification course sheet signed by your certified weapons instructor (i.e. NRA instructor, or police range instructor).

5. **MANDATORY-** Copy of your instructor's NRA, or FBI firearms instructor's certification.
6. **MANDATORY-** Typed letter submitted by the applicant stating the reason for the renewal of the conceal carry permit. This letter must be **NOTARIZED**. Photocopies will not be accepted.
7. **MANDATORY-** Submittal of all six (6) medical/mental health facility releases. The forms must be signed and dated where applicable. Single sided copies only. Do not submit double sided copies. **ILLEGIBLE** or **INCOMPLETE** documents will result in the rejection of the document by the medical facility.
8. RIGL 11-47-12 stipulates a permit fee of forty dollars (\$40) shall be charged for processing. Payment in the form of a check or money order payable to the City of Cranston will be collected at the time of permit issuance. **DO NOT SUBMIT ANY PAYMENT WITH APPLICATION.**

APPLICATION MUST INCLUDE THE ABOVE ENUMERATED THOROUGHLY COMPLETED DOCUMENTS OR THE APPLICATION WILL BE RETURNED FOR CORRECTION



RENEWAL APPLICATION FOR LICENSE TO CARRY A CONCEALED WEAPON

DATE _____ PERMIT NUMBER _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

NAME _____
FIRST MIDDLE LAST

ADDRESS _____
STREET (NO PO BOXES ACCEPTED) CITY STATE ZIP

EMAIL ADDRESS _____

PHONE _____
HOME BUSINESS CELL

SOCIAL SECURITY NUMBER _____ OCCUPATION _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

HEIGHT _____ WEIGHT _____ EYE COLOR _____ HAIR COLOR _____

**** IF APPLYING AS A BUSINESS MUST PROVIDE PROOF OF OWNERSHIP ****

BUSINESS NAME _____

BUSINESS ADDRESS _____
Street Name and Number (NO PO Boxes accepted) City or Town State & Zip

JOB DESCRIPTION _____

HAVE YOU EVER ARRESTED IN THE LAST 5 YEARS? _____

(IF YES PLEASE PROVIDE DETAILS ON A SEPARATE TYPED SHEET OF PAPER)

Before a Notary Public subscribed and sworn to me in _____, Rhode Island

Signed before me, this _____ day of _____, 20____.

Notary Public Signature

Applicant Signature

My commission Expires _____

NOTE: THE RI COMBAT COURSE IS FOR LAW ENFORCEMENT PERSONNEL ONLY. ALL OTHERS MUST QUALIFY IN ACCORDANCE TO §11-47-15

WEAPONS QUALIFICATION SCORE: CAL. OF WEAPON _____

ARMY-L _____ SCORE _____ RI COMBAT _____ SCORE _____

SIGNATURE OF N.R.A INSTRUCTOR OR POLICE RANGE OFFICER

PRINTED NAME & TELEPHONE # OF N.R.A. INSTRUCTOR OR POLICE RANGE OFFICER

N.R.A. # OR POLICE DEPARTMENT NAME

AFFIDAVIT

I CERTIFY THAT I HAVE READ AND I AM FAMILIAR WITH THE PROVISIONS OF R.I. GEN. LAWS §§ 11-47-1 TO 11-47-63 AND THAT I AM AWARE OF THE PENALTIES FOR VIOLATIONS OF THE PROVISIONS OF §§ 11-47-1 TO 11-47-63. I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS COMPLETE, TRUE AND CORRECT. I UNDERSTAND THAT A FAILURE TO PROVIDE COMPLETE, TRUE AND CORRECT INFORMATION IN THIS APPLICATION IS CAUSE FOR DENIAL OF THIS APPLICATION AND MAY LEAD TO CRIMINAL PROSECUTION. I FURTHER UNDERSTAND THAT ANY ALTERATION OF ANY CONCEALED WEAPON PERMIT ISSUED BY THE CITY OF CRANSTON IS CAUSE FOR REVOCATION.

Applicant's Signature

Applicant's Printed Name

Before a Notary Public subscribed and sworn to me in _____, Rhode Island	
Signed before me, this _____ day of _____, 20____.	
_____ Notary Public Signature	_____ Applicant Signature
My commission Expires _____	

FULLER HOSPITAL

— LEADING THE WAY IN BEHAVIORAL HEALTH —

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____ Last 4 of SS#: _____

To be released to or requested from:

Self (address above)
 Cranston Police Department (401) 477-5041 5 Garfield Avenue
Agency/Organization Telephone Number Street Address
Representative of Cranston PD (401) 477-5193 5 Garfield Avenue RI 02920
Name / Attention to Fax Number City State Zip Code

Via (only when released to): Mail Fax Pick-up Email: _____
 Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

Continuing Care Disability Determination Child Custody Personal Use
 Academic Legal Investigation Billing/Insurance Other: CCW permit application

Dates of Service Requested: _____

I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records, or

I authorize the release of the following information excluding all records that include any substance use disorder and/or substance use disorder treatment records,

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

Continuity/Transition of Care Packet Physician Orders
 Psychiatric Evaluation Lab/Diagnostic Reports
 History and Physical HIV Test Results and AIDS Treatment Records
 Discharge Summary Other: _____
 Progress Notes

This authorization will expire on ___/___/20___. (If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing:

Patient's signature (required for ages 18 and older) _____ Parent/Legal Guardian signature (if applicable) _____ Relationship to Patient _____

Witness signature/Credentials _____ Date Signed _____

This authorization is intended to allow Fuller Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

Revocation Signature _____ Date/Time _____



10136

Care New England

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN FULL PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE PATIENT NAME AND

PATIENT NAME

DOB OR MR

AUTHORIZATION TO RELEASE HEALTH INFORMATION

10136 (1-2022)

1. Patient name: _____ ("Patient") Date of Birth: _____ Telephone: _____

Address: _____ Med. Rec. #: _____
Street City State Zip

2. The undersigned hereby authorizes the following CNE Provider Butler Hospital
(Insert Hospital/Facility/Physician name) (the "Provider")

Address: 345 Blackstone Blvd., Providence, RI 02906
Street City State Zip

Telephone: _____ Fax: _____

to release/disclose (including verbal) to the individual and/or entity named in Section 3 ("Recipient") AND/OR

to request/receive (including verbal) from the individual and/or entity named in Section 3 ("Disclosing Party") the protected health information ("Health Information") specified in Section 4

3. Recipient or Disclosing Party: Representative of Cranston Police Dept. (Insert Individual/Entity Name)

Telephone: 401-477-5041 Fax Number (if Health Information is to be faxed): 401-477-5193

Address: 5 Garfield Avenue, Cranston, RI 02920
Street City State Zip

4. Please check one or more types of Health Information to be released/requested:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> X-Ray/Imaging Results | <input checked="" type="checkbox"/> Psychiatric Exam |
| <input type="checkbox"/> Emergency Dept. Records** | <input type="checkbox"/> History & Physical | <input checked="" type="checkbox"/> Psychological Tests |
| <input type="checkbox"/> Registration Record | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plan(s) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Entire Record |

OTHER (Please specify): _____

**An authorization for Emergency Department Records may include any of the above listed Health Information records.

5. Time frame for which the Health Information authorized in Section 4 above should be released/requested:

For the period from ALL (insert start date) through ALL (insert end date);
OR ALL DATES OF TREATMENT _____ (Please initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information. DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (Please specify): _____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)

Medical Care Legal Insurance Personal

Other (Please describe): _____

Conceal Carry Weapon Permit

8. The undersigned acknowledges and understands each of the following:

- authorizing the release of the Patient's Health Information is voluntary;
- refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility for benefits;
- this authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization;
- unless previously revoked, this authorization will automatically expire TWELVE (12) months from the date of signature below unless a shorter timeframe specified here _____ (enter date authorization will expire);
- any information released to the Recipient may be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.

THE UNDERSIGNED (1) HAS READ AND UNDERSTANDS THIS AUTHORIZATION; (2) HAS HAD ANY QUESTIONS WITH RESPECT TO THIS AUTHORIZATION EXPLAINED TO HIS/HER SATISFACTION; (3) IS AUTHORIZED TO SIGN THIS AUTHORIZATION INDIVIDUALLY AS THE PATIENT OR AS THE PATIENT'S LEGAL REPRESENTATIVE; AND (4) HEREBY EXPRESSLY AND VOLUNTARILY AUTHORIZES THE RELEASE/REQUEST OF THE PATIENT'S HEALTH INFORMATION AS SPECIFIED ABOVE.

Signature of Patient or Legal Representative of Patient

Date/Time

PRINT name of Patient or Legal Representative of Patient

Relationship to Patient or Authority to Act for Patient

TPC Internal Use Only: Process Hold

THIS AUTHORIZATION SHALL BE INVALID UNLESS ALL APPLICABLE SECTIONS ARE COMPLETE

Authorization for Release of Protected or Privileged Health Information

Please print all information clearly in order to process your request in a timely manner.

A. Patient information

Patient Name: _____ **Date of Birth:** _____

Medical Record #: _____

Address: Street: _____ Apt. #: _____
 City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____

B. Permission to share: I give my permission to share my protected health information.

Records from:

Name of Site Location: _____

Practice Name: _____

Provider Name: _____

Purpose: (check the appropriate box)

- Medical Care
- Insurance*
- Legal*
- Personal
- School
- Other* (please specify) Concealed Carry Permit

*Copying fees may apply

Send records to (Enter where you would like Mass General Brigham to send your information to):

Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below:

Name: Representative of Cranston Police Dept

Address: 5 Garfield Avenue

Cranston RI 02920

Telephone Number: (401) 477-5041

Send by:

- Mass General Brigham Patient Gateway (if available)
- Secure Email
Email Address: _____
- Fax (provide fax number): (401) 477-5193
- Paper Copy via Mail

C. Information to be released (please check all that apply, and MUST specify dates):

- Date(s) of Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary) _____
- Date(s) of Clinic Visit Notes _____
- Date(s) of Discharge Summary _____
- Date(s) of Lab Reports _____
- Date(s) of Operative Reports _____

- Date(s) of Pathology Reports _____
- Date(s) of Radiation Reports _____
- Date(s) of Radiology Reports _____
- Date(s) of Photographs _____
- Date(s) of Billing Records _____
- Other (please specify below and include dates)

Authorization for Release of Protected or Privileged Health Information

D. Please check YES to indicate if you give permission to release the following information if present in your record:

- Yes HIV test results (Patient authorization required for each release request.)
Specify dates _____
- Yes Genetic Screening test results
Specify type of test _____
- Yes Substance Use Disorder Treatment Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.) This consent may be revoked upon oral or written request.
- Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)
- Yes Confidential Communications with a Licensed Social Worker
- Yes Details of Domestic Violence/ Intimate Partner Abuse Counseling
- Yes Details of Sexual Assault Counseling

E. I understand and agree that:

- Mass General Brigham cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Mass General Brigham may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
 - if Mass General Brigham has already processed the request (for example, once information is released, it will not be retrieved)
 - if I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire 6 months from the date signed unless otherwise specified: _____
- I understand that if Mass General Brigham maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

Patient's Signature: _____ **Date:** _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only: Information Released/Reviewed By: _____ Date: _____

Picked up by: _____ Pick-up Identification: License State ID Passport Other Photo ID _____



**STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

1. I, _____
(Print first name, last name & date of birth of the Individual for whom information is being requested)

2. I hereby authorize the following information to be released: (check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Continuity of Care Forms | <input checked="" type="checkbox"/> Therapy Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Social Service Records | <input type="checkbox"/> Inter-Agency Referral(s) | <input type="checkbox"/> Financial Records |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> School/Edu. Records | <input type="checkbox"/> Billing Requests/Reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Reports | <input checked="" type="checkbox"/> Psychology Records | <input type="checkbox"/> Vocational Records |
| <input type="checkbox"/> Other (please be specific) <u>Psychological and/or substance abuse treatment/counseling</u> | | | |

3. I hereby authorize the following information not to be released*: (check all that apply)

- Substance Abuse/dependency/diagnosis/treatment/referral (42 CFR) Mental Health/diagnosis/treatment/referral
- HIV Test results /AIDS related information/(ARC) diagnosis and/or treatment
- Diagnoses and/or treatment relating to other communicable diseases

* This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

4. My information is to be obtained from:

Eleanor Slater Hospital
(Name of Organization)
PO Box 8269
(Address)
Cranston, RI 02920
(City/State/Zip)
Alyssa Carl
(Contact Name and Telephone Number)

5. My information is to be released to:

Rep of Cranston Police Department Phone 401-477-5041
(Name of Organization)
5 Garfield Avenue
(Address)
Cranston, RI 02920
(City/State/Zip)
(Contact Name and Telephone Number)

6. This authorization is for information applicable to the time period specified below:

From: ALL To: ALL

Method of Communication:
 Verbal Printed Materials

7. Concealed Carry Weapon Permit

(Indicate the specific purpose or need for this release of information)

8. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations. BHDDH may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization. I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective except to the extent that the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has already taken action in reliance on my authorization. I understand that this authorization will remain in effect until I revoke it in writing, or upon my discharge from the hospital. (If not an inpatient, expires within 1 year of date of signature). I further understand that, pursuant to applicable law, certain information may be disclosed without my authorization. My instructions to revoke my authorization should be directed to:

(Name and address of BHDDH Records person responsible for this request)

9. Signature of individual: _____ Date: _____

10. Signature of authorized representative _____ Relationship: _____

Print Name: _____ Date: _____

For Office Use Only:	Information Released: Y N	Date of Release:
Staff Person Releasing Information:		

Authorization for Release of
Specifically Protected Information

I request the release of the specific categories of information that I have INITIALED below:

____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)

SPECIFY DATE(S): _____

____ Records pertaining to Sexually-Transmitted Diseases

Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

____ Other(s): Please List _____

Confidential Details of:

Psychotherapy (from a Psychiatrist, Psychologist, or Psychiatric Clinical Nurse Specialist)
(cannot be authorized in conjunction with non psychotherapy authorization)

Other professional services of a licensed psychologist

____ Social Work Counseling/Therapy

____ Domestic Violence Victims' Counseling

____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management.
- Authorization may be withdrawn except for the following:
 - *To the extent that action has been taken in reliance on this statement
 - *If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization.
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by this rule.
- I understand that even if I do not withdraw this consent that this statement shall expire in:
(please check one): ____ 3 months ____ 6 months ____ 12 months ____ Other
(if no time is indicated authorization will expire in one year)

I have carefully read and understand the above, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____ Relationship, if not patient _____

Print Name: _____ Witness: _____ Date: _____

Basis of Authority to act on behalf of the patient

TO BE COMPLETED BY OFFICE STAFF/FACILITY RELEASING INFORMATION:

Date ___/___/___ ID Verified: Y / N # Pages (if) Given to Patient _____ Initials: _____

Type of Delivery: Email _____ Mail _____ Other _____



ROI



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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 information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)

Providence VA Medical Center (860 Chalkstone Ave., Providence, RI 02908)

LAST NAME- FIRST NAME- MIDDLE NAME

DATE OF BIRTH (mm/dd/yyyy)

PATIENT'S MAILING ADDRESS (including City, State and Zip Code)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Representative of the Cranston PD, 5 Garfield Ave, Cranston RI 02920 Fax 401-477-5193

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify below):

Concealed Carry Permit

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- HEALTH SUMMARY (Prior 2 Years)
PATIENT MEDICAL RECORDS (Dates):
INPATIENT DISCHARGE SUMMARY (Dates):
PROGRESS NOTES:
SPECIFIC CLINICS (Name & Date Range):
SPECIFIC PROVIDERS (Name & Date Range):
DATE RANGE:
OPERATIVE/CLINICAL PROCEDURES (Name & Date):
LAB RESULTS:
SPECIFIC TESTS (Name & Date):
DATE RANGE:
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS:
VACCINATION (Dose, Lot Number, Date & Location):
ADMINISTRATIVE RECORDS:
OTHER (Describe): Psychiatric records

LAST NAME- FIRST NAME- MIDDLE NAME		DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.		
I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.		
<input checked="" type="checkbox"/> DRUG ABUSE <input checked="" type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE <input type="checkbox"/> SICKLE CELL ANEMIA <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (HIV)		
I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure.		
<input type="checkbox"/> I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.		
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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.		
I understand that the VA health care provider'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.		
EXPIRATION: Without my express revocation, the authorization will automatically expire (select one of the following):		
<input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED		
<input type="checkbox"/> ON (mm/dd/yyyy) _____ (enter a future date other than date signed by patient)		
<input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____		
PATIENT SIGNATURE (Sign in ink)		DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT
FOR VA USE ONLY		
TYPE AND EXTENT OF MATERIAL RELEASED		
DATE RELEASED (mm/dd/yyyy)		RELEASED BY: