OMB 2900-XXXX
Estimated Burden 10 minutes

Department of Veterans Affairs

Consent Form for Release of Medical Records

Follow-Up Study of a National Cohort of Gulf War and Gulf Era Veterans

PAPERWORK REDUCTION ACT INFORMATION: This information is collected in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. Accordingly, VA may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. VA anticipates that the time expended by all individuals who complete this survey will average 10 minutes. This includes the time it will take to read instructions, gather the necessary facts, and fill out the survey. The information requested on this survey will be used to help VA assess the health status of veterans and plan health care services.

PRIVACY ACT STATEMENT: The information requested on this survey is solicited under authority of 38 U.S.C. Section 7303. It is being collected to assist VA in learning more about the health of Veterans and will help VA to provide better medical care. The information you supply will be confidential and protected by the provisions of the Privacy Act of 1974 (5 U.S.C. 552a) and specifically the VA system of records entitled 34VA12, "Veteran, Patient, Employee and Volunteer Research and Development Project Records - VA." Releases of the information may only be made with your consent or as identified in a "routine use" of the system of records. Routine uses include releases of statistical data and non-identifying data for research and associated administrative purposes. Disclosure is voluntary; failure to furnish the requested information will have no adverse effect on any VA benefit to which you may be entitled.

Notice: Information shown on this form which would identify any individual, health care provider or medical facility has been collected with a guarantee that it will be held in strict confidence. The information will be used for research by the Department of Veterans Affairs study team for the "Follow-up Study of a National Cohort of Gulf War and Gulf Era Veterans" and the study contractors. The information will not be disclosed or released to others without the consent of the individual.

This is to certify that I:

_____,
Print Full Name

born on_____, Social Security No. ___ ___ ___-___ ___-___ ___ ___ ___
Your Date of Birth

☐ Consent to the release of medical records

☐ Do not consent to the release of medical records

This release of medical records will only be used for research. I understand my information will be kept strictly confidential. This release of medical records* is for a health care visit for «reason for visit/diagnosis» that occurred between <<Month, Year>> and <<Month, Year>> with the following doctor or health care provider:

_____
Name of doctor or health care provider you visited

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Name of medical facility you visited

Address of medical facility

City, State and Zip Code of medical facility

Signature

Date

* Instead of sending medical records, your doctor or health care provider may choose to verify this health condition