OMB Control No. 2900-0001
Respondent Burden: 5 minutes

Department of Veterans Affairs

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at http://reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000 (TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. DATE OF BIRTH (MM,DD,YYYY)	3. VETERAN'S VA FILE NUMBER

4. CLAIMANT'S NAME *(If other than Veteran)* LAST NAME, FIRST, MIDDLE	5. VETERAN'S SOCIAL SECURITY NUMBER
6. RELATIONSHIP OF CLAIMANT TO VETERAN	**7. CLAIMANT'S SOCIAL SECURITY NUMBER**

SECTION II - SOURCE OF PERTINENT INFORMATION (Please use a separate form for each source)

8A. LIST THE SOURCE OF INFORMATION OR PROVIDER OF MEDICAL TREATMENT FOR YOUR CLAIMED CONDITION(S) *(Include the first and last name, complete address, and telephone number)*	8B. DATE(S) OF TREATMENT: *(Include the time period (month and year) for which the provider in Item 8A treated you for your currently claimed condition(s)* NOTE - "Treatment" includes office visits, hospitalizations, telephone consultations, etc.	8C. LIST THE DISABILITY(IES) FOR WHICH YOU FILED YOUR CURRENT CLAIM AND THAT WERE TREATED BY THE PROVIDER IN ITEM 8A
Source of Information (other than medical treatment provider):		
First Name, Last Name of Medical Treatment Provider:		
Complete Address and Telephone No. of Source of Information or Medical Treatment Provider:		

9. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 10C.

SECTION III - CONSENT TO RELEASE INFORMATION

READ ALL PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 9C.

10A. **Privacy Act Notice:** The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

10B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 8A to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 8A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 8A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If you do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

10C. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the source shown in Item 8A to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

11A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	11B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State)*	11C. DATE

11D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	11E. TELEPHONE NUMBER *(Include Area Code)*

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

12A. SIGNATURE OF WITNESS	12B. DATE

12C. MAILING ADDRESS OF WITNESS