OMB Control Number: 2900-XXXX
Estimate Burden: 15 minutes

Department of Veterans Affairs
Health Eligibility Center

Declaration of Representative

The VA is required to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995.	
The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38 and Title 26 U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.	
Veteran's Full Name	Veteran's Social Security Number
Spouse's Full Name (if applicable)	Spouse's Social Security Number (if applicable)
Veteran's Address (Street, City & Zip Code)	Veteran's Telephone Number
Representative's Full Name	Representative's Address & Telephone Number

I hereby appoint the above named organization or individual as my representative and authorize the Department of Veterans Affairs (VA) to release confidential tax information and other income and medical benefits eligibility related records maintained by the Health Eligibility Center for income year ~Income Year~.

Without my express revocation, this authorization shall remain in full force for ~Income Year~.

Redisclosure of the aforementioned information or record by my representative other than to VA is not authorized without my further written consent.

I certify that the information has been made freely, voluntarily and without coercion.

Veteran's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____
(if applicable)