



DECLARATION OF REPRESENTATIVE

PRIVACY ACT INFORMATION: Title 38, United States Code, Sections 501(a), 1705, 1710, 1722, 5317 and Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990 grants the Department of Veterans Affairs (VA) the authority to verify Veterans' self-reported household income to determine eligibility for medical benefits. The VA also has the authority to verify Veterans' self-reported income with the Internal Revenue Service (IRS) and Social Security Administration (SSA). With the exception of Federal Tax Information (FTI), VA may make routine use disclosure under the authority of 45 CFR Parts 160 and 164 which permits such disclosures. The information being requested is voluntary, however failure to provide the information requested may delay or result in the denial of your health care benefits. Failure to furnish the information request will however not affect any benefits for which you are already deemed eligible due to service connection.

THE PAPERWORK REDUCTION ACT OF 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

GENERAL INFORMATION

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.

1. VETERAN'S NAME (<i>Last, First, Middle Name</i>)	2. SOCIAL SECURITY NUMBER
3. SPOUSE'S FULL NAME (<i>Last, First, Middle Name</i>)	4. SPOUSE'S SOCIAL SECURITY NUMBER
5. VETERAN'S ADDRESS (<i>Street, City & Zip Code</i>)	6. VETERAN'S TELEPHONE NUMBER
7. REPRESENTATIVE'S FULL NAME (<i>Last, First, Middle Name</i>)	8. REPRESENTATIVE'S TELEPHONE NUMBER
9. REPRESENTATIVE'S ADDRESS (<i>Street, City & Zip Code</i>)	

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 current income year. Income Year: _____

Without my express revocation, this authorization shall remain in full force for this year.

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

I certify that this authorization has been made freely, voluntarily and without coercion

10. VETERAN'S SIGNATURE	11. DATE SIGNED (<i>MM/DD/YYYY</i>)
12. SPOUSE'S SIGNATURE (<i>If applicable</i>)	13. DATE SIGNED (<i>MM/DD/YYYY</i>)