OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: XX/XX/20XX

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

GENERAL RELEASE FOR MEDICAL PROVIDER INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to provide the name of the provider or facility you have received treatment from to the VA. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly, and insert one letter per box, to help expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER — – –

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* – –

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING *(If other than veteran)*

6. PATIENT'S NAME *(First, Middle Initial, Last)*

7. SOCIAL SECURITY NUMBER — – –

8. VA FILE NUMBER

SECTION III - MEDICAL PROVIDER INFORMATION

9A. PROVIDER OR FACILITY NAME	9B. CONDITIONS YOU ARE BEING TREATED FOR	9C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)*
		From: – – To: – –

9D. PROVIDER/FACILITY STREET ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

10A. PROVIDER OR FACILITY NAME	10B. CONDITIONS YOU ARE BEING TREATED FOR	10C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 10A)*
		From: – – To: – –

10D. PROVIDER/FACILITY STREET ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

11A. PROVIDER OR FACILITY NAME	11B. CONDITIONS YOU ARE BEING TREATED FOR	11C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 11A)*
		From: ___ – ___ – ____ To: ___ – ___ – ____

11D. PROVIDER/FACILITY STREET ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

12A. PROVIDER OR FACILITY NAME	12B. CONDITIONS YOU ARE BEING TREATED FOR	12C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 12A)*
		From: ___ – ___ – ____ To: ___ – ___ – ____

12D. PROVIDER/FACILITY STREET ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

13A. PROVIDER OR FACILITY NAME	13B. CONDITIONS YOU ARE BEING TREATED FOR	13C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 13A)*
		From: ___ – ___ – ____ To: ___ – ___ – ____

13D. PROVIDER/FACILITY STREET ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

PRIVACY ACT INFORMATION: 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 Veteran Readiness 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.

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0858, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 5 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0858 in any correspondence. Do not send your completed VA Form 21-4142a to this email address.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false.