Department of Veterans Affairs

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

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

SECTION II—SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC.(Include ZIP Codes, and also a telephone number, if available)	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. (Include month and year)	7C. CONDITION(S) (Illness, injury, etc.)

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9C.

SECTION III —CONSENT TO RELEASE INFORMATION

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

9A. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Privacy Act of 1974, 5 U.S.C. 552a, 38 U.S.C. 7332, and the Health Insurance Portability and Accountability Act (HIPAA), implemented by 45 Code of Federal Regulations Parts 160 and 164. Your disclosure of the information requested on this form 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. Further, 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.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A to release any information that may have been obtained in connection with 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 7A 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 7A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If I do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

9C. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the above source to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism, 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:

10A. SIGNATURE OF VETERAN/CLAIMANT	10B. 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.)*	10C. DATE

10D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	10E. 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.

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS