

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM CLAIMANT'S RECORDS

NOTE: 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, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside the VA as permitted by law to include disclosures as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary. However, if the information is not furnished, we may not be able to comply with your request.

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| TO | <small>Veterans Administration</small> DEPARTMENT OF VETERAN AFFAIRS | NAME OF VETERAN (Type or print) | |
| | 1. | VA FILE NO. (Include prefix) | SOCIAL SECURITY NO. |
| 2. | | 3. | |

NAME AND ADDRESS OF ORGANIZATION, AGENCY, OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED.

4. COPY SERVICE AND LAW FIRM COMPLETE

VETERAN'S REQUEST

I hereby request and authorize the Veterans Administration to release the following information, from the records identified above to the organization, agency, or individual named hereon:

INFORMATION REQUESTED (Number each item requested and give the dates or approximate date-period from and to-covered by each.)

5. PLEASE INDICATE WITH A CHECK MARK ALL ITEM(S) YOU WISH TO BE RELEASED:

- Psychiatric
 Drug Abuse
 Infection with Human Immunodeficiency Virus (HIV)
 Alcoholism or Alcohol Abuse
 Sickle Cell Anemia
 Copies of any and all Hospital Reports/Summaries from _____ to _____
 Copies of the Outpatient Treatment Notes from _____ to _____
 If you are submitting an insurance form to be completed or need any other statement from your medical record, your chief complaint, treatment dates, diagnosis, operations and off-work dates if applicable from _____ to _____
 Other. Please specify and give approximate treatment dates: _____

6. IF THERE IS ANY INFORMATION THAT YOU DO NOT WANT RELEASED, PLEASE SPECIFY HERE:

PURPOSES FOR WHICH THE INFORMATION IS TO BE USED

- 7.** Insurance Company Employer
 Disability Forms Other (specify) _____
 Private Physician/Hospital

8. UNLESS OTHERWISE NOTED, THIS CONSENT IS VALID FOR ONE (1) YEAR FROM THE DATE OF MY SIGNATURE.

NOTE: Additional items of information desired may be listed on Me reverse hereof.

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| DATE 9. | SIGNATURE AND ADDRESS OF CLAIMANT, OR FIDUCIARY, IF CLAIMANT IS INCOMPETENT 10. |
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