



Department of Veterans Affairs

VA DATE STAMP  
(DO NOT WRITE IN THIS SPACE)AUTHORIZATION TO DISCLOSE 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 your written authorization to obtain your treatment records, so the VA can get the information required to process your claim. 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 relay number is 711. VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms). For mailing information see page 3.

[two days ago], 2021 VA Claim Intake  
Center, Janesville, WI  
BEST COPY - PMR PROGRAM  
REFERRED

## SECTION I - VETERAN 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)

F r a n k l i n D C o l l i n s

2. SOCIAL SECURITY NUMBER

6 Y 1 - 7 X - X 0 0

3. VA FILE NUMBER (If applicable)

6 Y 1 7 X X 0 0

4. DATE OF BIRTH (MM/DD/YYYY)

0 5 - 1 4 - 1 9 9 8

5. VETERAN'S SERVICE NUMBER (If applicable)

6 Y 1 X X 0

6. MAILING ADDRESS (Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)

No. &amp; Street 3 1 H o p k i n s P l a z a

Apt./Unit Number City B a l t i m o r e

State/Province M D Country U S ZIP Code/Postal Code 2 1 2 0 1 -

7. TELEPHONE NUMBER (Include Area Code)

5 5 5 - 5 5 5 - 1 2 1 2

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS (Optional)

☐ I agree to receive electronic correspondence from VA in regards to my claim.

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

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

10. SOCIAL SECURITY NUMBER

11. VA FILE NUMBER (If applicable)

## SECTION III - INFORMATION REGARDING SOURCE OF RECORD(S)

## SOURCE OF RECORD(S):

- ALL medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities,
- Social workers/rehabilitation counselors,
- Consulting examiners used by VA,
- Employers, insurance companies, workers' compensation programs, and
- Others who may know about my condition (family, neighbors, friends, public officials).

## SECTION IV - RECORDS TO BE RELEASED TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of: **All my medical records; including information related to my ability to perform tasks of daily living. This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:
  - a. Psychological, psychiatric, or other mental impairment(s) excluding "psychotherapy notes" as defined in 45 C.F.R. §164.501,
  - b. Drug abuse, alcoholism, or other substance abuse,
  - c. Sickle cell anemia,
  - d. Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS,
  - e. Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months *after* the date this authorization is signed in Item 13, as well as past information.

YOU SHOULD NOT COMPLETE THIS FORM UNLESS YOU WANT THE VA TO OBTAIN PRIVATE TREATMENT RECORDS ON YOUR BEHALF. IF YOU HAVE ALREADY PROVIDED THESE RECORDS OR INTEND TO OBTAIN THEM YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM. DOING SO WILL LENGTHEN YOUR CLAIM PROCESSING TIME. THIS FORM IS NOT NEEDED TO REQUEST VA MEDICAL RECORDS.

**IMPORTANT** - In accordance with 38 C.F.R. §3.159(c), "VA will not pay any fees charged by a custodian to provide records requested."

12. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE (If this space is left blank, there is no limitation to records):

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above in Section I.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties (See page 2 for details).
- I may write to VA and my source(s) to revoke this authorization at any time (See page 2 for details).
- VA will give me a copy of this form, if I ask; I may also ask the source(s) to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed. See Patient Acknowledgment below.**

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**NOTE:** For additional information regarding VA Form 21-4142, refer to the following website: <https://www.benefits.va.gov/privateproviders/>.

## WHERE TO SEND YOUR WRITTEN CORRESPONDENCE

Documents may be submitted by mail, in person at a VA regional office or electronically. However, VA recommends submitting correspondence electronically as this is the fastest method of receipt.

VA provides several tools to assist in electronic submission. To learn more about how to submit documents and claims electronically, visit [www.va.gov/disability/upload-supporting-evidence](http://www.va.gov/disability/upload-supporting-evidence). You can also go directly to [access.va.gov](http://access.va.gov) to digitally upload any correspondence using Direct Upload.

By visiting [www.va.gov](http://www.va.gov) you can also check your claims status and learn about other VA benefits.

If you need assistance, you can find a local, accredited representative at <https://www.benefits.va.gov/vso/>.

If you prefer to mail your correspondence, please use the related mailing address below.

COMPENSATION CLAIMS	PENSION & SURVIVORS BENEFIT CLAIMS
Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444	Department of Veterans Affairs Pension Intake Center PO Box 5365 Janesville, WI 53547-5365
FIDUCIARY	BOARD OF VETERANS' APPEALS
Department of Veterans Affairs Fiduciary Intake PO Box 95211 Lakeland, FL 33804-5211	Department of Veterans Affairs Board of Veterans' Appeals PO Box 27063 Washington, DC 20038

**These addresses serve all United States and foreign locations.**



Department of Veterans Affairs

VA DATE STAMP  
(DO NOT WRITE IN THIS SPACE)**APPOINTMENT OF VETERANS SERVICE ORGANIZATION  
AS CLAIMANT'S REPRESENTATIVE****IMPORTANT:** Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.**NOTE:** If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. When completed you can mail **or** fax this form to the appropriate intake center address shown on Page 4. VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms).**SECTION I: VETERAN'S INFORMATION****NOTE:** You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

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

F r a n k l i n D C o l l i n s

2. VETERAN'S SOCIAL SECURITY NUMBER (SSN)

6 Y 1 - 7 X - X 0 0

3. VA FILE NUMBER (If applicable)

6 Y 1 7 X X 0 0

4. VETERAN'S DATE OF BIRTH

Month Day Year  
0 5 - 1 4 - 1 9 9 8

5. VETERAN'S SERVICE NUMBER (If applicable)

6. INSURANCE NUMBER(S) (If applicable) (Include letter prefix)

7. VETERAN'S MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. &amp; Street 3 1 H o p k i n s P l a z a

Apt./Unit Number City B a l t i m o r e

State/Province M D Country U S ZIP Code/Postal Code 2 1 2 0 1 -

8. VETERAN'S TELEPHONE NUMBER (Include Area Code)

9. VETERAN'S EMAIL ADDRESS (Optional)

**SECTION II: CLAIMANT'S INFORMATION (If other than veteran)**

10. CLAIMANT'S NAME (First, Middle Initial, Last)

11. CLAIMANT'S MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. &amp; Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code -

12. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)

13. CLAIMANT'S EMAIL ADDRESS (Optional)

14. RELATIONSHIP TO VETERAN

**SECTION III: SERVICE ORGANIZATION INFORMATION**

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on Page 3 before selecting organization)

Disabled American Veterans

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 (This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)

John Smith

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A  
DAV NSO

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

JohnSmith.DAV@email.com

18. DATE OF THIS APPOINTMENT (MM/DD/YYYY)

[two days ago]

VETERAN'S SOCIAL SECURITY NUMBER

6 Y 1 - 7 X - X 0 0

## SECTION IV: AUTHORIZATION INFORMATION

**19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.** - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

- ☒ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

**20. LIMITATION OF CONSENT-** I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

- ☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)  
☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

**21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS** - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

- ☒ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 *or* 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

## SECTION V: SIGNATURES

**NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC**

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*

*Franklin D. Collins*

22B. DATE SIGNED *(MM/DD/YYYY)*

[two days ago]

23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A  
*(Do Not Print)*

John Smith, DAV NSO

23B. DATE SIGNED *(MM/DD/YYYY)*

[two days ago]

**NOTE:** As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO:	DATE SENT	ACKNOWLEDGED <i>(Date)</i>	REVOKED <i>(Reason and date)</i>
	<input type="checkbox"/> VR&E FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> LG FILE <input type="checkbox"/> INSURANCE FILE			

**PENALTY:** The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

## RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association	National Association of County Veterans Service Officers, Inc.
American Legion	National Association for Black Veterans, Inc.
American Red Cross	National Veterans Legal Services Program
AMVETS	National Veterans Organization of America
American Ex-Prisoners of War, Inc.	Navy Mutual Aid Association
American GI Forum, National Veterans Outreach Program	Paralyzed Veterans of America, Inc.
Armed Forces Services Corporation	Polish Legion of American Veterans, U.S.A.
Army and Navy Union, USA	Swords to Plowshares, Veterans Rights Organization, Inc.
Associates of Vietnam Veterans of America	The Retired Enlisted Association
Blinded Veterans Association	The Veterans Assistance Foundation, Inc.
Catholic War Veterans of the U.S.A.	The Veterans of the Vietnam War, Inc. & The Veterans
Disabled American Veterans	Coalition
Fleet Reserve Association	United Spanish War Veterans of the United States
Gold Star Wives of America, Inc.	United Spinal Association, Inc.
Italian American War Veterans of the United States, Inc.	Veterans of Foreign Wars of the United States
Jewish War Veterans of the United States	Veterans of World War I of the U.S.A., Inc.
Legion of Valor of the United States of America, Inc.	Vietnam Era Veterans Association
Marine Corps League	Vietnam Veterans of America
Military Officers Association of America (MOAA)	West Virginia Department of Veterans Assistance
Military Order of the Purple Heart	Wounded Warrior Project
National Amputation Foundation, Inc.	

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims:

Alabama	Hawaii	Minnesota	North Dakota	Tennessee
American Samoa	Idaho	Mississippi	Northern Mariana Islands	Texas
Arizona	Illinois	Missouri	Ohio	Utah
Arkansas	Iowa	Montana	Oklahoma	Vermont
California	Kansas	Nebraska	Oregon	Virginia
Colorado	Kentucky	Nevada	Pennsylvania	Virgin Islands
Connecticut	Louisiana	New Hampshire	Puerto Rico	Washington
Delaware	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming
Guam	Michigan	North Carolina		

**PRIVACY ACT NOTICE:** 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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. 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. 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. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

**RESPONDENT BURDEN:** We need this information to recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at [www.reginfo.gov/public/do/PRAMain](http://www.reginfo.gov/public/do/PRAMain). If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FOR ALL **COMPENSATION** CLAIMS MAIL OR FAX THIS FORM TO THE FOLLOWING ADDRESS:

Mail your form to:  
 Department of Veterans Affairs  
 Claims Intake Center  
**P.O. Box 4444**  
 Janesville, WI 53547-4444  
**Or** fax your form to:  
 Toll Free: (844) 531-7818  
 Local: 248-524-4260

FOR **VETERANS PENSION** AND **SURVIVOR BENEFIT** CLAIMS MAIL OR FAX THIS FORM TO THE APPROPRIATE ADDRESS SHOWN BELOW:

Mail your form to:  
 Department of Veterans Affairs  
 Claims Intake Center  
**Attn: Milwaukee Pension Center**  
**P.O. Box 5192**  
 Janesville, WI 53547-5192  
**Or** fax your form to:  
 Toll Free: (844) 655-1604

**This Pension Center Serves The Following:**

Alabama	Arkansas	Illinois	Indiana
Kentucky	Louisiana	Michigan	Mississippi
Missouri	Ohio	Tennessee	Wisconsin

Mail your form to:  
 Department of Veterans Affairs  
 Claims Intake Center  
**Attn: Philadelphia Pension Center**  
**P.O. Box 5206**  
 Janesville, WI 53547-5206  
**Or** fax your form to:  
 Toll Free: (844) 655-1604

**This Pension Center Serves The Following:**

Connecticut	Delaware	Florida	Georgia
Maine	Maryland	Massachusetts	New Hampshire
New Jersey	New York	North Carolina	Pennsylvania
Rhode Island	South Carolina	Vermont	Virginia
West Virginia	District of Columbia	Puerto Rico	Canada
Countries outside of North, Central or South America			

Mail your form to:  
 Department of Veterans Affairs  
 Claims Intake Center  
**Attn: St. Paul Pension Center**  
**P.O. Box 5365**  
 Janesville, WI 53547-5365  
**Or** fax your form to:  
 Toll Free: (844) 655-1604

**This Pension Center Serves The Following:**

Alaska	Arizona	California	Colorado
Hawaii	Idaho	Iowa	Kansas
Minnesota	Montana	Nebraska	Nevada
New Mexico	North Dakota	Oklahoma	Oregon
South Dakota	Texas	Utah	Washington
Wyoming	Mexico	Central America	South America
Caribbean			

## DEPARTMENT OF VETERANS AFFAIRS

Any City Regional Office

PO Box 313

Any City AS 21010

[today], 2021

Dr. W.L. Leipold  
31 Hopkins Plaza, Suite 378  
Baltimore, MD 21201

In reply, refer to:  
101/1 PRE/mg  
File Number:  
6Y17XX00  
Franklin Collins

### IMPORTANT -- reply needed

The Veteran, Franklin D. Collins, has applied for disability benefits showing treatment by you.

Please furnish copies of your treatment records to include findings and diagnoses for treatment the Veteran received during the following period:

Hearing loss and tinnitus: 11/02/2020 to Present

We have enclosed VA form 21-4142, authorization and Consent to Release Information to the Department of Veterans Affairs, or its equivalent, signed by the Veteran. This letter is being sent in duplicate so that you may retain a copy. Attach the other copy of our letter to your reply to ensure proper identification. A self-addressed envelope is enclosed for your convenience.

Sincerely yours,

*Dawn Key*

Dawn Key

Veterans Service Center Manager

Enclosure VA Form 21-4142/signed release

s: Self-addressed envelope



## DEPARTMENT OF VETERANS AFFAIRS

[today], 2021

Dr. R. Detty  
31 Hopkins Plaza, Suite 6  
Baltimore, MD 21201

In reply, refer to:  
101/1 PRE/mg  
File Number:  
6Y17XX00  
Franklin Collins

**IMPORTANT -- reply needed**

The Veteran, Franklin D. Collins, has applied for disability benefits showing treatment by you.

Please furnish copies of your treatment records to include findings and diagnoses for treatment the Veteran received during the following period:

Right shoulder and left knee: 11/02/2020 to Present

We have enclosed VA form 21-4142, authorization and Consent to Release Information to the Department of Veterans Affairs, or its equivalent, signed by the Veteran. This letter is being sent in duplicate so that you may retain a copy. Attach the other copy of our letter to your reply to ensure proper identification. A self-addressed envelope is enclosed for your convenience.

Sincerely yours,

*Dawn Key*

Dawn Key

Veterans Service Center Manager

Enclosure VA Form 21-4142/signed release

s: Self-addressed envelope

## DEPARTMENT OF VETERANS AFFAIRS

Any City Regional Office

PO Box 313

Any City AS 21010

[today], 2021

Dr. Pepper  
31 Hopkins Plaza, Suite 23  
Baltimore, MD 21201

In reply, refer to:  
101/1 PRE/mg  
File Number:  
6Y17XX00  
Franklin Collins

### IMPORTANT -- reply needed

The Veteran, Franklin D. Collins, has applied for disability benefits showing treatment by you.

Please furnish copies of your treatment records to include findings and diagnoses for treatment the Veteran received during the following period:

Depression: 11/02/2020 to Present

We have enclosed VA form 21-4142, authorization and Consent to Release Information to the Department of Veterans Affairs, or its equivalent, signed by the Veteran. This letter is being sent in duplicate so that you may retain a copy. Attach the other copy of our letter to your reply to ensure proper identification. A self-addressed envelope is enclosed for your convenience.

Sincerely yours,

*Dawn Key*

Dawn Key

Veterans Service Center Manager

Enclosure VA Form 21-4142/signed release

s: Self-addressed envelope