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

OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: 03/31/2021

Department of Veterans Affairs

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE ENTIRE FORM *(both pages)* BEFORE SIGNING IN ITEM 11 BELOW.

SECTION I - 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 11, 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.

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."**

SECTION II - VETERAN IDENTIFICATION INFORMATION

NOTE - You can *either* complete the form online or by hand. Please print the information requested in ink, neatly, and legibly to help process the form.

1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*: Franklin D Collins

2. SOCIAL SECURITY NUMBER: 6Y1 – 7X – X00

3. VA FILE NUMBER: 6Y17XX00

4. DATE OF BIRTH *(MM/DD/YYYY)*: 05 – 14 – 1998

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

6. MAILING ADDRESS (*Number and street or rural route, P. O. Box, City, State, ZIP Code and Country*)
   - No. & Street: 31 Hopkins Plaza
   - Apt./Unit Number:
   - City: Baltimore
   - State/Province: MD
   - Country: US
   - ZIP Code/Postal Code: 21201 –

7. E-MAIL ADDRESS *(Optional)*:

8. TELEPHONE *(Include Area Code)*: (555) 555-1212

SECTION III - 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 IV - 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).

VETERAN'S SOCIAL SECURITY NO. 6 Y 1 – 7 X – X 0 0

SECTION V - AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO VA AND SIGNATURE

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)*:

TO WHOM: The Department of Veterans Affairs (VA).
PURPOSE: Determining my eligibility for benefits, and whether I can manage such benefits.
EXPIRES: This authorization is good for 12 months from the date shown in Item 12.

- 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 Acknowledgement below.**

13. SIGNATURE OF PERSON AUTHORIZING DISCLOSURE ***(Required)*** *(Sign in ink)*	14. DATE SIGNED *(MM/DD/YYYY)* ***(Required)***
Franklin D. Collins	[two days ago], 2021
15. PRINTED NAME OF PERSON SIGNING *(First, Middle Initial, Last)*	16. 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)*
Franklin D. Collins	Veteran

NOTE: This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical and other information under P.L. 104-191 ("HIPAA"); 45 C.F.R. parts 160 and 164; 42 U.S.C. §290dd-2; 42 C.F.R. part 2, and State Law.

PRIVACY ACT NOTICE: 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 Vocational Rehabilitation 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 source 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.

If you do not revoke this authorization, it will automatically expire in 12 months from the date you sign and date the form. Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by VA without your consent if authorized by Federal laws such as the Privacy Act.

Under the Government Paperwork Elimination Act (GPEA) (Public Law 105-277), the Office of Management and Budget (OMB) ensures that agencies, when practicable, provide for the option of electronic maintenance, submission of disclosure of information and for the use and acceptance of electronic signatures. GPEA states that electronic records submitted or maintained in accordance with the procedures developed by OMB, or electronic signature or other forms of electronic authentication used in accordance with such procedures, "shall not be denied legal effect, validity, or enforceability merely because such records are in electronic form" (Public Law 105-277, section 1707).

RESPONDENT BURDEN: We need this information and your written authorization to obtain your treatment records to help us get the information required to process your claim. Title 38, United States Code, allows us to ask for this information. You can provide this authorization by signing VA Form 21-4142. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations. 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. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form. If you use the Telecommunications Device for the Deaf (TDD), the Federal relay number is 711.

PATIENT ACKNOWLEDGMENT: I HEREBY AUTHORIZE the sources listed in Section IV, to release any information that may have been obtained in connection with a 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 source being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it provides me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my source 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 in writing, at any time except to the extent a source of information has already relied on it to take an action. To revoke, I must send a written statement to the VA Regional Office handling my claim or the Board of Veterans' Appeals (if my claim is related to an appeal) and also send a copy directly to any of my sources that I no longer wish to disclose information about me. I understand that VA may use information disclosed prior to revocation to decide my claim.

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

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

OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: 03/31/2021

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 - COMPLETE AND ATTACH THIS FORM WITH A SIGNED VA FORM 21-4142, *AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)*. IF YOU HAVE MORE THAN FIVE PROVIDERS, FILL OUT ADDITIONAL COPIES OF THIS FORM, AVAILABLE AT **WWW.VA.GOV/VAFORMS**.

NOTE - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BELOW BEFORE COMPLETING THIS FORM.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

Franklin D Collins

2. SOCIAL SECURITY NUMBER: 6Y1 – 7X – X00

3. VA FILE NUMBER:

4. DATE OF BIRTH *(MM/DD/YYYY)*: 05 – 14 – 1998

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 *(If applicable)*:

SECTION III - MEDICAL PROVIDER INFORMATION

9A. PROVIDER OR FACILITY NAME	9B. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)*
Dr. W. Leipold	From: 11/02/2020 To: Present From: To:

9C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. & Street: 31 Hopkins Plaza
Apt./Unit Number: 378
City: Baltimore
State/Province: MD
Country:
ZIP Code/Postal Code: 21201 –

10A. PROVIDER OR FACILITY NAME	10B. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 10A)*
Dr. Detty	From: 11/02/2020 To: Present From: To:

10C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. & Street: 31 Hopkins Plaza
Apt./Unit Number: 6
City: Baltimore
State/Province: MD
Country:
ZIP Code/Postal Code: 21201 –

VETERAN'S SOCIAL SECURITY NO. 6Y1 – 7X – X00

11A. PROVIDER OR FACILITY NAME	11B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 11A)*
Dr. Pepper	From: 11/02/2020 To: Present
	From: To:

11C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. & Street: 31 Hopkins Plaza

Apt./Unit Number: 23 City: Baltimore

State/Province: MD Country: ZIP Code/Postal Code: 21201 –

12A. PROVIDER OR FACILITY NAME	12B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 11A)*
	From: To:
	From: To:

12C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. & Street:

Apt./Unit Number: City:

State/Province: Country: ZIP Code/Postal Code: –

13A. PROVIDER OR FACILITY NAME	13B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 11A)*
	From: To:
	From: To:

13C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. & Street:

Apt./Unit Number: City:

State/Province: Country: ZIP Code/Postal Code: –

PRIVACY ACT NOTICE: 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 Vocational Rehabilitation and Employment Records - VA, and 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: We need this information to obtain your treatment records. 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. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

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.

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)*

Franklin D Collins

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*

6Y1 – 7X – X00

3. VA FILE NUMBER *(If applicable)*

6Y17XX00

4. VETERAN'S DATE OF BIRTH

Month 05 – Day 14 – Year 1998

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. & Street: 31 Hopkins Plaza

Apt./Unit Number:

City: Baltimore

State/Province: MD

Country: US

ZIP Code/Postal Code: 21201 –

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. & 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)*	22B. DATE SIGNED *(MM/DD/YYYY)*
Franklin D. Collins	[two days ago]
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	**23B. DATE SIGNED** *(MM/DD/YYYY)*
John Smith, DAV NSO	[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 *(Date)*	REVOKED *(Reason and date)*
	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ 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
American Legion
American Red Cross
AMVETS
American Ex-Prisoners of War, Inc.
American GI Forum, National Veterans Outreach Program
Armed Forces Services Corporation
Army and Navy Union, USA
Associates of Vietnam Veterans of America
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
Military Order of the Purple Heart
National Amputation Foundation, Inc.
National Association of County Veterans Service Officers, Inc,
National Association for Black Veterans, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
The Veterans Assistance Foundation, Inc.
The Veterans of the Vietnam War, Inc. & The Veterans Coalition
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars of the United States
Veterans of World War I of the U.S.A., Inc.
Vietnam Era Veterans Association
Vietnam Veterans of America
West Virginia Department of Veterans Assistance
Wounded Warrior Project

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**. 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

Enclosures: VA Form 21-4142/signed release
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

Enclosures: VA Form 21-4142/signed release
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

Enclosures: VA Form 21-4142/signed release
Self-addressed envelope