[redacted]

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

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

[redacted]

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

[redacted]

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)

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

10. 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 on Page 2.**

[redacted]

,YYYY) ***(Required)***

13. PRINTED NAME OF PERSON SIGNING *(First, Middle Initial, Last)*

14. TELEPHONE NUMBER *(Include Area Code)*

15. 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)*

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

[redacted]

OMB Control No 2900-0001
Respondent Burden 5 minutes
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Department of Veterans Affairs

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

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

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 THREE PROVIDERS, FILL OUT ADDITIONAL COPIES OF THIS FORM. AVAILABLE AT **WWW.VA.GOV/VAFORMS**

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

[redacted]

SECTION II - MEDICAL PROVIDER INFORMATION

4A PROVIDER OR FACILITY NAME	4B DATE(S) OF TREATMENT *(Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)*
[redacted]	From 01 01 1995 To 12 31 2000 From To
[redacted]	TELEPHONE NUMBER *(Include Area Code)*
5A PROVIDER OR FACILITY NAME	5B DATE(S) OF TREATMENT *(Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)*
	From To From To
5C PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*	
5D CITY / 5E STATE AND ZIP CODE	5F PROVIDER OR FACILITY TELEPHONE NUMBER *(Include Area Code)*
6A PROVIDER OR FACILITY NAME	6B DATE(S) OF TREATMENT *(Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)*
	From To From To
6C PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*	
6D CITY / 6E STATE AND ZIP CODE	6F PROVIDER OR FACILITY TELEPHONE NUMBER *(Include Area 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.