OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: 07/31/2024

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:** Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to provide the name of the provider or facility you have received treatment from to the VA. 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 Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

## SECTION I - VETERAN'S 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)*

2. SOCIAL SECURITY NUMBER ___ – ___ – ____

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* __ – __ – ____

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

## SECTION III - MEDICAL PROVIDER INFORMATION

| 9A. PROVIDER OR FACILITY NAME | 9B. CONDITIONS YOU ARE BEING TREATED FOR | 9C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)* |
|---|---|---|
| | | From: __ – __ – ____<br>To: __ – __ – ____ |

9D. PROVIDER/FACILITY STREET 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 – ____

| 10A. PROVIDER OR FACILITY NAME | 10B. CONDITIONS YOU ARE BEING TREATED FOR | 10C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 10A)* |
|---|---|---|
| | | From: __ – __ – ____<br>To: __ – __ – ____ |

10D. PROVIDER/FACILITY STREET 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 – ____

VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

| 11A. PROVIDER OR FACILITY NAME | 11B. CONDITIONS YOU ARE BEING TREATED FOR | 11C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 11A)* |
|---|---|---|
| | | From: ___ – ___ – ____<br>To: ___ – ___ – ____ |

11D. PROVIDER/FACILITY STREET 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 – ____

| 12A. PROVIDER OR FACILITY NAME | 12B. CONDITIONS YOU ARE BEING TREATED FOR | 12C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 12A)* |
|---|---|---|
| | | From: ___ – ___ – ____<br>To: ___ – ___ – ____ |

12D. PROVIDER/FACILITY STREET 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 – ____

| 13A. PROVIDER OR FACILITY NAME | 13B. CONDITIONS YOU ARE BEING TREATED FOR | 13C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 13A)* |
|---|---|---|
| | | From: ___ – ___ – ____<br>To: ___ – ___ – ____ |

13D. PROVIDER/FACILITY STREET 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 – ____

**PRIVACY ACT INFORMATION**: 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 Veteran Readiness 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 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.

**PENALTY:** The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false.