



APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER <i>(Include prefix)</i>
3. NAME ONLY OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS <i>(See list on reverse side before selecting organization)</i>	

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER	5. INSURANCE NUMBER(S) <i>(Include letter prefix)</i>		
6A. SERVICE NUMBER(S)	6B. BRANCH OF SERVICE		
7. NAME OF CLAIMANT <i>(If other than veteran)</i>	8. RELATIONSHIP <i>(If other than veteran)</i>		
9. ADDRESS OF CLAIMANT <i>(No. and street or rural route, city or P.O., State and ZIP Code)</i>	10. CLAIMANT'S TELEPHONE NUMBER <i>(Include Area Code)</i>		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">A. DAYTIME ()</td> <td style="width: 50%; border: none;">B. EVENING ()</td> </tr> </table>	A. DAYTIME ()	B. EVENING ()
A. DAYTIME ()	B. EVENING ()		
	11. DATE OF THIS APPOINTMENT		

NOTE: Complete Item 12 only if claim filed for disability insurance benefits.

12. TYPE OF DISABILITY INSURANCE BENEFITS FILED FOR

NSLI USGLI NSLI AND USGLI

13. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I **do not 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 3 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 above, either by explicit revocation or the appointment of another representative.

14. LIMITATION OF CONSENT. My consent in Item 13 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

I, the claimant named in Items 1 or 7, hereby appoint the service organization named in Item 3 as my representative to prepare, present and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 1. I authorize the Department of Veterans Affairs to release any and all of my records *(other than as provided in Items 13 and 14)* to that service organization appointed as my representative. It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney. I understand that the service organization I have appointed as my representative may revoke this power of attorney at any time, subject to 38 C.F.R. §20.608. Signed and accepted subject to the foregoing conditions.

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

15. SIGNATURE OF CLAIMANT (Do Not Print)	16. DATE SIGNED
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VA USE ONLY	VA FORM 21-22-1 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)	REVOKED <i>(Reason and date)</i>
	<input type="checkbox"/> CER FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> INSURANCE FILE <input type="checkbox"/> CH. 30 <input type="checkbox"/> DEA FILE <input type="checkbox"/> LG FILE			

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



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(DO NOT WRITE IN THIS SPACE)
 VA DATE STAMP

**VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION,
 VA Form 21-526, Part A: General information**

Please read the attached "General Instructions" before you fill out this form.

SECTION I Tell us what you are applying for

Check the box that says what you are applying for. Be sure to complete the other Parts you need.

1. What are you applying for? If you are unsure please refer to the "General Instructions" page 2
 Section 1: Preparing your application

Compensation ▶ Fill out Part A of Form 21-526 and Parts B and C

Pension ▶ Fill out Part A of Form 21-526 and Parts C and D

Compensation and Pension ▶ Fill out Part A of VA Form 21-526 and Parts B, C and D

2a. Have you ever filed a claim with VA

No (If "No," skip Item 2b and go to Item 3)
 (If "Yes," provide file number below)

Yes _____ (Go to 2b)

2b. I filed a claim for

Compensation Pension

Other _____

SECTION II Tell us about you

We need information about you to process your claim faster.

Give us your current mailing address in the space provided. If it will change within the next three months, give us that new address in block 29 "Remarks." Also in block 29, give us the date you think you will be at the new address.

OWCP used to be called the U.S. Bureau of Employees Compensation

3. What is your name?

First Middle Last Suffix (If applicable)

4. What is your Social Security number? _____

5. What is your sex?

Male Female

6a. Did you serve under another name?

Yes (If "Yes," go to Item 6b)

No (If "No," go to Item 7)

6b. Please list the other name(s) you served under

7. What is your address?

Street address, rural route, or P.O. Box Apt. number

City State ZIP Code Country

8. What are your telephone numbers?

Daytime () _____

Evening () _____

9. What is your e-mail address?

10. What is your date of birth?

____/____/____

month day year

11. Where were you born?

City State Country

12a. Are you receiving disability benefits from the Office of Workers' Compensation (OWCP)?

Yes No

(If "Yes," answer 12b and 12c also)

12b. When was the claim filed?

____/____

month year

12c. What disability are you receiving benefits for?

13a. What is the name of your nearest relative or other person we could contact if necessary?

13c. What is his/her telephone number?

Daytime () _____

Evening () _____

13b. What is this person's address?

13d. How is this person related to you?

SECTION III Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed use Item 29 "Remarks"

2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)

The VA has a registry of veterans who served in the Gulf War. This area has also been called the "Persian Gulf." If you served there, we will include your name in the registry. If you want your medical information included, you must check "Yes" in Item 16b. For more information about the registry, see page 4 of the **General Instructions for VA Form 21-526.**

14a. I entered active service the first time. . . / / mo day yr	14b. Place:	14c. My service number was . . .	
14d. I left this active service. . . / / mo day yr	14e. Place:	14f. Branch of Service	14g. Grade, rank, or rating
14h. I entered my second period of active service. . . / / mo day yr	14i. Place:	14j. My service number was . . .	
14k. I left this active service. . . / / mo day yr	14l. Place:	14m. Branch of Service	14n. Grade, rank, or rating
15a. Did you serve in Vietnam? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 15b also)		15b. When were you in Vietnam? from to / / / / mo day yr mo day yr	
16a. Were you stationed in the Gulf after August 1, 1990? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 16b also)		16b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?" <input type="checkbox"/> Yes <input type="checkbox"/> No	
17a. Have you ever been a prisoner of war? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 17b , 17c , and 17d also)		17b. What country or government imprisoned you?	
17c. When were you confined? from to / / / / mo day yr mo day yr		17d. What was the name of the camp or sector and what are the names of the city and country near its location	

SECTION IV Tell us about your reserve duty

18a. Are you currently assigned to an active reserve unit? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 18b also)	18b. What is the name, mailing address, and telephone number of your current unit?
18c. Were you previously assigned to an active reserve unit within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 18d also)	18d. What is the name, mailing address, and telephone number of that unit?

<p>SECTION IV (Continued) Tell us about your reserve duty</p>	<p>18e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>(If "Yes," answer Item 18f also)</p>	<p>18f. What is your reserve obligation termination date?</p> <p>____/____/____ mo day yr</p>
<p>Instructions 18g-18k If you are currently or have ever been a full time reservist for operational or support duty,</p> <p>1. Complete 18g-18k for that service only.</p> <p>2. Attach proof of reserve service</p>	<p>18g. I entered reserve service. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>18h. My service number was . . .</p>	
<p>Instructions 18l-18p If your disability occurred or was aggravated during any period of reserve duty,</p> <p>1. Complete 18l-18p for the period when your disability occurred.</p> <p>2. Attach proof that your disability occurred during reserve service.</p>	<p>18i. I left reserve service. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>18j. Branch of service</p> <p>18k. Grade, rank, or rating</p> <hr/> <p>18l. I entered reserve service. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>18m. My service number was . . .</p> <hr/> <p>18n. I left reserve service. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>18o. Branch of service</p> <p>18p. Grade, rank, or rating</p>	
<p>SECTION V Tell us about your National Guard duty</p>	<p>19a. Are you currently a member of the National Guard?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assigned yet</p> <p>(If "Yes," answer Item 19b also)</p>	<p>19b. What is the name, mailing address, and telephone number of your current unit?</p>
<p>Instructions 19e-19i If you were activated to Federal Active Duty under the Authority of Title 10, United States Code,</p> <p>1. Complete 19e-19i for that service only.</p> <p>2. Attach proof of this Federal Active Duty</p>	<p>19c. Were you previously assigned to a guard unit within the last 2 years?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 19d also)</p> <hr/> <p>19e. I entered Federal Active Duty. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19f. My service number was . . .</p> <hr/> <p>19g. I left Federal Active Duty. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19h. Branch of service</p> <p>19i. Grade, rank, or rating</p>	
<p>Instructions 19j-19n If your disability occurred or was aggravated during any period of guard duty,</p> <p>1. Complete 19j-19n for the period when your disability occurred.</p> <p>2. Attach proof that your disability occurred during National Guard Service.</p>	<p>19j. I entered National Guard. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19k. My service number was . . .</p> <hr/> <p>19l. I left National Guard. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19m. Branch of service</p> <p>19n. Grade, rank, or rating</p>	

SECTION VI Tell us about your travel status	20a. Were you injured while traveling to or from your military assignment? <i>(If "Yes," answer Items 20b thru 20e and Section I of Part B: Compensation)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	20b. When did your injury happen? / / mo day yr	20c. Where did your injury happen? <i>(City, State, Country)</i>	20d. Where were you treated? (Provide name and address of Doctor's office, hospital, etc.)	20e. What agency did you file an accident report with?
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SECTION VII Tell us about your military benefits <i>When you file this application, you are telling us that you want to get VA compensation instead of military retired pay. If you currently receive military retired pay, you should be aware that we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes.</i> You must sign 21e if you want to keep getting military retired pay instead of VA compensation. <i>Please see page 4 of the General Instructions for VA Form 21-526.</i> <i>If you have gotten both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of VSI, by the Department of De</i>	21a. Are you receiving or will you receive retired or retainer pay that is based on your military service? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," answer Items 21b thru 21f. If "No," skip to Item 22)</i>	21b. What branch of service is paying or will pay your retired or retainer pay?	21c. What is the monthly amount? \$ _____
	21d. What is your retirement based on? <input type="checkbox"/> Length of service <input type="checkbox"/> Disability <input type="checkbox"/> TDRL (Temporary Disability Retired List)		
	21e. Sign here if you want to receive military retired pay <i>instead of</i> VA compensation _____		

21f. Have you received or will you receive any of the following military benefits? <i>(Please check the appropriate boxes and tell us the amount)</i>	
Benefit	Amount
(1) <input type="checkbox"/> Lump Sum Readjustment Pay	\$ _____
(2) <input type="checkbox"/> Separation pay under 10 USC 1174	\$ _____
(3) <input type="checkbox"/> Special Separation Benefit (SSB)	\$ _____
(4) <input type="checkbox"/> Voluntary Separation Incentive (VSI)	\$ _____
(5) <input type="checkbox"/> Disability Severance Pay <i>(name of disability _____)</i>	\$ _____
(6) <input type="checkbox"/> Other <i>(tell us the type of benefit _____)</i>	\$ _____

SECTION VIII Give us direct deposit information If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, " All federal payments... " and then either: 1. Attach a voided check, or 2. Answer questions 22-24 to the right.	All federal payments beginning January 2, 1999, must be made by electronic funds transfer (EFT) also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 22, 23 and 24 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 22. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004 and give us a brief description of why you do not wish to participate in Direct Deposit.
	22. Account number <i>(Please check the appropriate box and provide that account number, if applicable)</i> <input type="checkbox"/> Checking <input type="checkbox"/> I certify that I do not have an account with a financial institution or certified payment agent <input type="checkbox"/> Savings Account number _____
	23. Name of financial institution _____

24. Routing or transit number _____

SECTION IX Give us your signature

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

I certify and authorize the release of information:
 I certify that the statements in this document are true and complete to the best of my knowledge. Any physician, dentist, or hospital that has treated or examined me, or that I have consulted professionally, may give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

25. Your signature		26. Today's date ____ / ____ / ____ <i>mo day yr</i>
27a. Signature of witness (If claimant signed above using an "X")	27b. Printed name and address of witness	
28c. Signature of witness (If claimant signed above using an "X")	28b. Printed name and address of witness	

SECTION X

Remarks - Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension

IMPORTANT

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, or for the fraudulent acceptance of any payment which you are not entitled to.

29. Remarks (If you need more space to answer a question or have a comment about a specific item number on this form please identify your answer or statement by the item number)



VA Form 21-526, Part B: Compensation

Use this form to apply for compensation. Remember that you must also fill out a VA Form 21-526, Part A: General Information, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 2.

SECTION I Tell us about your disability

In the table below, tell us more about your disability or disabilities. Be sure to:

- List all disabilities you believe are related to military service.
List all the treatments you received for your disabilities, including treatments you received in a military facility before and after discharge, and treatments you received from civilian and VA sources before, during, and after your service.

Table with 5 columns: 1. What disability are you claiming?, 2. When did your disability begin?, 3. When were you treated?, 4a. What medical facility or doctor treated you?, 4b. What is the address of that medical facility or doctor? The table contains 10 rows of empty form fields for data entry.

SECTION II Tell us if any of the disabilities you listed on Page 1 were because of exposures	5a. Were you exposed to Agent Orange or other herbicides? Yes No <i>(If "Yes," answer Items 5b and 5c also)</i>	5b. What is your disability?	5c. In what country were you exposed?	
	6a. Were you exposed to asbestos? Yes No <i>(If "Yes," answer Item 6b and 6c also)</i>	6b. What is your disability?		
		6c. When and how were you exposed?		
	7a. Were you exposed to mustard gas? Yes No <i>(If "Yes," answer Item 7b and 7c also)</i>	7b. What is your disability?		
		7c. When and how were you exposed?		
	8a. Were you exposed to ionizing radiation? Yes No <i>(If "Yes," answer Items 8b, 8c, and 8d also)</i>	8b. What is your disability?	8c. When was your last exposure? _____ / _____ / _____ <i>mo day yr</i>	
	8d. How were you exposed to radiation?	Atmospheric testing Nagasaki/Hiroshima Other, describe _____		
9a. Were you exposed to an environmental hazard in the Gulf War? Yes No <i>(If "Yes," answer Items 9b and 9c also)</i>	9b. What is your disability?	9c. What was the hazard?		
10a. Did you have a separation or retirement physical examination? Yes No <i>(If "Yes," answer Items 10b and 10c also)</i>	10b. When was the exam? _____ / _____ / _____ <i>mo day yr</i>	10c. Where did the exam occur?		

SECTION III Tell us how your disabilities listed on Page 1 are related to your military service	11. Explanation
--	------------------------

Your Name	Your Social Security Number
------------------	------------------------------------

SECTION II Tell us about any previous marriages

NOTE: You should provide copies of divorce decrees or death certificates

In the table below, tell us about:
 ● Your previous marriages, and
 ● Your spouse's previous marriages

Your previous marriages

13a. How many times have you been married before? _____

13b. When were you married?	13c. Where were you married? <i>(city/state or country)</i>	13d. Who were you married to?	13e. When did your marriage end?	13f. Why did your marriage end? <i>(death, divorce)</i>	13g. Where did your marriage end? <i>(city/state or country)</i>
____/____/____ <i>mo day yr</i>			____/____/____ <i>mo day yr</i>		
____/____/____ <i>mo day yr</i>			____/____/____ <i>mo day yr</i>		

Your spouse's previous marriages

14a. How many times has your current spouse been married before? _____

14b. When was your spouse married?	14c. Where was your spouse married? <i>(city/state or country)</i>	14d. Who was your spouse married to?	14e. When did your spouse's marriage end?	14f. Why did your spouse's marriage end? <i>(death, divorce)</i>	14g. Where did your spouse's marriage end? <i>(city/state or country)</i>
____/____/____ <i>mo day yr</i>			____/____/____ <i>mo day yr</i>		
____/____/____ <i>mo day yr</i>			____/____/____ <i>mo day yr</i>		

SECTION III Tell us about your other dependents

In this section we want to know whether your parents are financially dependent on you (Question 15) and more about your **dependent children**. VA may recognize a veteran's biological children, adopted children, and stepchildren as dependent. These children must be unmarried and:

- be under the age of 18, **or**
- be at least 18 but under 23 and pursuing an approved course of education, **or**
- have become permanently unable to support themselves before reaching the age of 18.

You should provide: a copy of the public record of birth for each child or a copy of the court record of adoption for each adopted child.

15. Are your parents financially dependent on you?
 Yes No *(If "Yes," we will request additional information from you later)*

16. Do you have dependent children?
 Yes
(If "No," Skip Items 17-21f). Go to the bottom of page 3 and write your name and Social Security number)
 No

17. How many dependent children do you have?

Give us more information about these children in the tables on the next page (Items 18 through 21f)

SECTION III Tell us about your dependents (continued)

18a. What is the name of your unmarried child? <i>(first, middle initial, last)</i>	18b. Date and place of birth	18c. Social Security Number	19a. Biological	19b. Adopted	19c. Stepchild	20a. 18-23 yrs. old and in school	20b. Seriously disabled before age 18	20c. Child previously married
	<div style="text-align: center;"> / / mo day yr Place: </div>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<div style="text-align: center;"> / / mo day yr Place: </div>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<div style="text-align: center;"> / / mo day yr Place: </div>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<div style="text-align: center;"> / / mo day yr Place: </div>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tell us about your dependents listed above who *don't* live with you

21a. Do all the children listed above live with you?

Yes *(If "Yes," skip Items 21b thru 21f and write your name and Social Security number below)*

No *(If "No," complete Item 21b and the table below (Items 21c -21f) and write your name and Social Security number below)*

21b. How many of the children do not live with you?

21c. What is the name of your child? <i>(first, middle initial, last)</i>	21d. What is your child's complete address?	21e. What is the name of the person your child lives with (If applicable)?	21f. How much do you contribute each month to the support of your child?
			\$.
			\$.
			\$.
			\$.

Your name	Your Social Security Number
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AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000
(TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN <i>(Type or print)</i>	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME <i>(If other than Veteran)</i> LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC. <i>(Include ZIP Codes, and also a telephone number, if available)</i>	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. <i>(Include month and year)</i>	7C. CONDITION(S) <i>(Illness, injury, etc.)</i>

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9C.

SECTION III - CONSENT TO RELEASE INFORMATION

READ ALL PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 9C.

9A. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Privacy Act of 1974, 5 U.S.C. 552a, 38 U.S.C. 7332, and the Health Insurance Portability and Accountability Act (HIPAA), implemented by 45 Code of Federal Regulations Parts 160 and 164. Your disclosure of the information requested on this form 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. Further, 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.

9B. I, the undersigned, hereby authorize the hospital, physician or other caregiver shown in Item 7A, to release any information that may have been obtained in connection with 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 once my health care provider 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 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, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 7A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If I do not revoke this authorization, it will automatically end 180 days from the date I sign this form (block 10C).

9C. I (AUTHORIZE) (DO NOT AUTHORIZE) the above source to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism, alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. **IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:**

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE

10B. 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)*

10C. DATE

10D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*

10E. TELEPHONE NUMBER *(Include Area Code)*

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

11A. SIGNATURE OF WITNESS

11B. DATE

11C. MAILING ADDRESS OF WITNESS

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