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)*

2. SOCIAL SECURITY NUMBER ___ – ___ – ____

3. VA FILE NUMBER

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

4. 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)*
	From: To: From: To:

9C. 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 –

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)*
	From: To: From: To:

10C. 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 –

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

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)*
	From: To: From: To:

11C. 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 –

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.