Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054, SOUTHFIELD, MI 48086-5054

P: 248-357-3330 F: 248-357-3337 E: REQUESTS@RECDEP.COM

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☑ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☑ OTHER *(Describe)*: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY:

REQUEST FOR VA BILLING
FOR CARE RELATED TO PERSONAL INJURY OR WORKERS COMPENSATION

INSTRUCTIONS - Visit www.va.gov/ogc/collections.asp for the most up to date form prior to use.

1. **Complete the information for VA to process your request.**
   Failure to submit complete information may result in significant delays in processing your request.
   Attorney's Letter of Representation. If requested by, or on behalf of, a law firm/lawyer representing a party (includes record retrieval company for a law firm), send a letter of representation with your request.
2. **Click Print or Save using the Buttons displayed in Yellow at bottom of second page.**
3. **Select each VA Hospital that provided or paid for care to see the fax number to send the request.**
   Select the location(s) where accident-related care was provided from the drop down lists below. Locations listed are the locations of VA Hospitals. If care was provided at a VA clinic or a non-VA provider whose exact location is not listed below, choose the location closest to where the care was provided. If more than three VA Hospitals provided or paid for care, use an additional form. Requests must be faxed or mailed to all VA Hospitals that provided or paid for care in order for VA to produce billing for all related treatment. *If unable to Fax, the mailing address for each location selected will be displayed at bottom of second page.*

Select Location:

VETERAN AND INJURY DESCRIPTION

Veteran's Name (Last, First, Middle Initial)	
Veteran's Full Social Security Number	
Veteran's Mailing Address	
Veteran's Phone	
Describe Incident Resulting In Injury (Include Date and Location)	
Describe IN DETAIL Injuries Sustained / Nature of Disease DESCRIPTION MUST BE SPECIFIC	
List all VA Facilities Where Related Treatment Was Received	
If Related Treatment was provided at a Non-VA Facility, List all non-VA Providers	
Is Treatment Complete? If No, Describe Nature and Location of Ongoing Treatment	
Name of Veteran's Attorney	
Veteran's Attorney's Phone	
Veteran's Attorney's Mailing Address	
Veteran's Attorney's Email Address	
Veteran's Attorney's Fax	

VETERAN'S INSURANCE - *USE MULTIPLE SHEETS FOR MORE THAN ONE INSURER*

Identify Applicable Insurers & Type *Examples: No Fault Insurance, Medical Payments from Veteran's Liability Insurance, Under-/Un-insured Motorist Insurance*	
Insurer's Mailing Address	
Insurer's Phone	
Insurer's Fax	
Insurer's Email	
Insurance Adjuster and Claim#	
Insurance POLICY LIMITS Description	

RESPONSIBLE PARTY (DEFENDANT) - *USE MULTIPLE SHEETS FOR MORE THAN ONE PARTY*

Name and contact information for Tortfeasor / Employer if Workers Compensation	
Name and contact information for Attorney representing Tortfeasor / Employer if Workers Compensation	
Identify Tortfeasor/Workers' Compensation Insurer	
Insurer's Mailing Address	
Insurer's Phone	
Insurer's Email	
Insurer's Fax	
Insurance Adjuster and Claim #	
Insurance POLICY LIMITS Description	
Only if Workers' Compensation: Name, Address, and Reference # for Workers' Compensation Board/Commission	

Privacy Act: The authority for collection of the requested information is found within the following: 38 USC 501, 38 CFR 1.900 et. Seq.; 42 USC 2651-2653; 38 USC 1729; 28 CFR 43.2; and E.O. 9397. The purpose of collecting this information is to provide basic information from which potential liability can be assessed for VA to recover the cost of care from the liable party instead of the American taxpayer and Veteran paying for the care. Failure to provide any or all of the requested information may delay or result in VA's inability to create accident-related billing, assert a claim for reimbursement, and assist the Veteran in their personal injury or workers compensation claim. Without a third party paying for the care, the Veteran may owe VA copayments. Information on this form will become part of a system of records which complies with the Privacy Act of 1974. This system is identified as "Revenue Program Billing and Collections Records-VA (114VA16)" as set forth in the Compilation of Privacy Act Issuances via online GPO access. Assurances of privacy for information on this form which is covered under 38 USC 7332 are contained within that statute.