Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 36 U.S.C. 7332

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 it displays a valid OMB number. We expect that the time expended by all individuals completing this form will average 2 minutes. This includes the time to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to specifically outline the circumstances under which we may disclose data.

◄ 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 Title38, U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS *War Related Illness & Injury Study Center* *385 Tremont Ave., East Orange, NJ 07018*	PATIENT NAME *(Last, First, Middle Initial)* SOCIAL SECURITY NUMBER

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

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER *(Specify)*

Information regarding participation in research study.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED

To inform healthcare provider about GWV's participation in research including sending a Notification Letter and Treatment Recommendations. As appropriate, the Study Team may contact healthcare provider to coordinate care or discuss a health concern.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); or (3) under the following condition(s):

I understand that the VA health care practitioner'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.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD *(Name, Address, Social Security Number)*	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM10-5345