



**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](http://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: — —

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

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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: — —

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

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