



INDIVIDUALS' REQUEST FOR A COPY OF THEIR OWN HEALTH INFORMATION

PRIVACY ACT INFORMATION

The purpose of this form is to provide an individual the means to make a written request for a copy of their information maintained by the Department of Veteran Affairs (VA) in accordance with 38 CFR 1.577. The information on this form is requested under Title 38 U.S.C. 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. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled.

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

DESCRIPTION OF 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
OTHER (Describe):

COPY OF HEALTH INFORMATION IS TO BE DELIVERED TO THE INDIVIDUAL

- PAPER CD-ROM OTHER:
IN-PERSON PICK-UP, PROVIDE CONTACT PHONE NUMBER:
MAIL TO ADDRESS:

PATIENT SIGNATURE (Sign in ink)

DATE (mm/dd/yyyy)

NOTE: If signed by someone other than the individual, indicate the authority (e.g. guardianship or power of attorney) under which request is made.