INFORMATION REGARDING POSSIBLE CLAIM

AGAINST THIRD PARTY

(Protection of Privacy Addendum)

The information request on the form is solicited under authority of Public Law 87-693 and will be used to recover from tortuously liable third Persons or applicable insurance carrier the reasonable value of medical care which the V.A. may furnish you, it will not be used for any other purpose. Disclosure is mandatory failure to furnish the information will result in our In ability to obtaining payment and therefore, billing you for care furnished. Failure to furnishing this information will have no adverse effect on any other benefit to which you may be entitled.

VA Form 10-1023a

Department of Veterans Affairs

INFORMATION REGARDING POSSIBLE CLAIM AGAINST THIRD PARTY

TO	ADDRESS OF VA FACILITY **District Counsel (02)**	FROM	NAME AND ADDRESS OF VA FACILITY

VETERAN'S NAME *(Last, First, Middle Initial)*	TELEPHONE
VETERAN'S ADDRESS *(Number, Street, City, State, Zip Code)*	SOCIAL SECURITY NUMBER
	DATE OF THIS REPORT
NAME OF PERSON FURNISHING THIS INFORMATION, *if other than veteran (Last, First, Middle Initial)*	TELEPHONE
ADDRESS OF PERSON FURNISHING THIS INFORMATION *(if other than veteran)*	
NATURE OF INJURY OR DISEASE	
REIMBURSABLE INSURANCE *(INSURANCE COMPANY + ADDRESS, POLICY NUMBER: TYPE OF COVERAGE: GROUP OR INDIVIDUAL)*	
IF CLAIM OR CAUSE OF ACTION IS AGAINST A THIRD PARTY; GIVE NAME AND ADDRESS OF SUCH PARTY	

☐ TORT-FEASOR ☐ CRIMES OF PERSONAL VIOLENCE

☐ WORKER'S COMPENSATION ☐ "NO FAULT" INSURANCE

HAS VETERAN SUBMITTED CLAIM ORALLY OR IN WRITTING ☐ YES ☐ NO	IF SUBMITTED TO THAN THIRD PARTY NAMED ABOVE, TO WHOM AND WHEN WAS IT SUBMITTED

NAME, TELEPHONE NUMBER AND ADDRESSES OF WITNESSES
GIVE DATE, TIME, EXACT LOCATION AND DESCRIPTION OF INCIDENT WHICH RESULTED IN INJURY
WHAT AUTHORITIES, IF ANY, CONDUCTED INVESTIGATION OF INCIDENT

HAS VETERAN CONTACTED ATTORNEY ☐ YES ☐ NO	NAME AND ADDRESS OF ATTORNEY REPRESENTING VETERAN *(if applicable)*
REMARKS	

Department of Veterans Affairs

POWER OF ATTORNEY AND ASSIGNMENT

I hereby assign to the Department of Veterans Affairs any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the Department of Veterans Affairs. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the Department of Veterans Affairs or any other amount to which I may be entitled.

I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned.

I hereby authorize the Department of Veterans Affairs to disclose, to my attorney and to any third part or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the Department of Veterans Affairs any information regarding my claim.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF WITNESS	DATE

VA FORM JUL 1989 **2-4763**

SUPERSEDES VA FORM 2-4763, NOV 1969, AND VA FORM 10-2381, MAY 1963, WHICH WILL NOT BE USED.

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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 systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. 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 Paperwork Reduction Act of 1995. 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 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 instructions, gather the necessary facts and fill out the form.

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

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

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

NAME AND ADDRESS OF ATTORNEY OR INSURANCE COMPANY: _____

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)

ALL MEDICAL RECORDS AND BILLS FOR INJURY DATE: _____

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

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 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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (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 (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

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