Department of Veterans Affairs
Health Administration Center
CHAMPVA

FACT SHEET 06-01
Recurring Authorization

Sometimes I need help obtaining my benefits, but due to privacy laws the Health Administration Center will not discuss my health information with another person. Is there a simple way for me to designate another person to receive my health information when I need assistance in understanding my eligibility for benefits and in getting my claims paid?

Yes, you may authorize us to discuss and release personal information about your eligibility for benefits and claims information to another person on a recurring basis by completing the attached VA Form 10-5345, "Request for and Authorization to Release Medical Records or Health Information." Upon receipt of this form we may disclose your personal eligibility and claim information on a recurring basis to the individual you designate. This authorization remains in effect until you revoke it in writing.

For your convenience we printed the form with some required wording; however, you must complete the remaining blocks as described below.

This form may be signed only by:

- the person, or
- if the person is a minor by his or her parental custodian, or
- the individual's legally designated agent, such as power of attorney or court appointed guardian (supporting documentation must be submitted with the form)

Block	Block Title	Instruction
2	Patient Name	Print the Last Name, First Name, and Middle Initial of the person to whom the information pertains.
3	Social Security Number	Print the full Social Security number for the person listed in block 2.
4	Name and Address of Organization, Individual, or Title of Individual to Whom Information is to be Released	Print the full name and address of the person designated to receive your personal information. This is the person you want to receive the information.
5	Veteran's Request	This section is to be completed by the person to whom the information pertains. Check the applicable box(es) if there is information in your record about drug or alcohol abuse, sickle cell anemia, or HIV/AIDS, but only if you want the individual designated in block 4 to receive this type of information.
9	Date	Print the date you sign the form.
10	Signature of Patient or Person Authorized to Sign for Patient	Sign the form in this block, and then mail the form to: VA Health Administration Center, PO Box 469063, Denver, CO 80246-9063.

How do I get more information?

- Mail — VA Health Administration Center
  CHAMPVA
  PO Box 469063
  Denver CO 80246-9063
- Phone — 1-800-733-8387
- FAX: — 1-303-331-7804
- Email — Follow the directions for submitting secure email at this web link: **http://www.va.gov/hac/contact**
- Website — **www.va.gov/hac**

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 effect 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.

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

Health Administration Center
PO Box 469063
Denver, CO 80246-9063

2. PATIENT NAME (Last, First, Middle Initial)

3. SOCIAL SECURITY NUMBER

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

5. 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

6. 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 NOTES ☒ OTHER (SPECIFY)

I authorize the VA Health Administration Center to disclose any eligibility and claim information from my record to the above named individual.

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

The purpose of this authorization is for the above named individual to assist me in submitting claims to the Health Administration Center for payment consideration, to obtain or facilitate approval for requested medical services and supplies, to obtain information regarding the payment or denial of payment for claimed services and supplies, to discuss and resolve issues related to payment of claims or pre-certification of medical services and supplies, and to obtain information regarding my eligibility status for services administered by the VA Health Administration Center.

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

8. 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):

RECURRING DISCLOSURE AUTHORIZATION: I authorize the VA Health Administration Center to disclose the information as noted for the stated purposes to the above named individual in writing or verbally on a recurring basis without the need for any additional authorization. This authorization will remain in effect until I submit written revocation to the VA Health Administration Center.

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.

9. DATE	10. 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 *(Name, Address, Social Security Number)*	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY