AUTHORIZATION FOR RELEASE OF INFORMATION

(Please ensure all lines are completed. Non answered lines may delay response time.)

Name_____ **DOB**_____ **Phone #**_____

Maiden/Other Name_____ **SSN**_____ **SN**_____

Address_____
Street City State Zip

Branch of Military:_____ **AD/NG/Res** (Circle one) **Dates of Service:**_____ **Rank:**_____

I hereby authorize **North Dakota Army National Guard ATTN: NGND-G1-PSB, P.O. Box 5511,**
Name person/facility

Bismarck, ND 58506-5511 FAX: 701-333-3082
Address of person/facility

To release to:_____
Name of person/facility to receive information

_____
Address of person/facility to receive information

_____
Telephone: FAX:

The following information:

_____DD Form 214 (Active Duty discharge) _____NGB Form 22 (NG discharge)
_____NGB Form 23 (Retirement History) _____Medical documentation dated/related to:
_____Other: (Specify)

Reason for Request:

Requestor's Consent:
This authorization is voluntary and remains in effect unless specifically revoked by written notice to the facility or person or expires on_____. If an expiration date is not entered, authorization will expire one year from date of signature. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule. A photocopy of this release is as effective as the original. If Power of Attorney is used, a copy of Power of Attorney must accompany request.

Signature of Person or Responsible Party Relationship Date

Meets requirements of Health Insurance Portability and Accountability Act of 1996 (PL 104-191)

Send completed form(s) to:
North Dakota Army National Guard, ATTN:NGND-G1-PSB, P.O. Box 5511, Bismarck, ND 58506-5511
NDTAA FORM ROI Dated 10 January 2008