



## VIRGINIA DEPARTMENT OF VETERANS SERVICES

### AUTHORIZATION TO DISCLOSE INFORMATION TO VIRGINIA DEPARTMENT OF VETERANS SERVICES (VDVS) IN ORDER TO DETERMINE ELIGIBILITY FOR BENEFITS THROUGH THE VIRGINIA MILITARY SURVIVORS AND DEPENDENTS PROGRAM (VMSDEP)

Please complete and upload this form at the time of your online application submission or fax to:  
**Virginia Department of Veteran Services**  
**Virginia Military Survivors and Dependents Education Program (VMSDEP)**  
**Fax: (804) 786-0809**

**PURPOSE:** This form authorizes VDVS to access your U.S. Department of Veterans Affairs (VA) records from your Veterans Service Organization (VSO) representative, agent, or attorney in order to determine your dependent's eligibility for the Virginia Military Survivors and Dependents Education Program (VMSDEP). Your permission, as endorsed by your signature below, is required for VDVS to process your dependent's application.

**NOTE:** VDVS will not pay any fees charged by a custodian to provide records requested.

<b>Applicant's Name</b>	Last Name	First Name/MI	
<b>Veteran's Name</b>	Last Name	First Name/MI	
<b>SSN</b>		<b>DOB</b>	
<b>Veteran's Home Phone</b>	(    )       -		
<b>Veteran's Cell Phone</b>	(    )       -		
<b>I give permission for VDVS to obtain information from the following VSO representative, agent, or attorney for VMSDEP processing:</b>	Please list your VSO representative, agent, or attorney.		Telephone # (    )       -

**SIGNER'S ACKNOWLEDGMENT:** I HEREBY AUTHORIZE the listed VSO representative, agent, or attorney to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VDVS will use this information in determining my dependent's eligibility for VMSDEP. I understand that once my VSO representative, agent, or attorney sends this information to VDVS under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VDVS may disclose this information as authorized by law. I understand that the VSO representative, agent, or attorney being asked to provide VDVS with records under this authorization may refuse as the listed source is not obligated to release such information; upon which, I will be responsible for providing all information, as identified by VDVS, to fully evaluate my dependent's request for VMSDEP eligibility determination. I also understand that I may revoke this authorization in writing; and to revoke, I must send a written statement to VDVS and also send a copy directly to the listed VSO representative, agent, or attorney that I no longer wish to disclose information about me. I understand that VDVS may use information disclosed prior to revocation to act on my dependent's request for determination of eligibility for benefits under the VMSDEP.

**Veteran's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**VDVS USE ONLY:**

Document:	Date Received:	Staff:	Application Number: