Veterans Affairs Canada | Anciens Combattants Canada

Protected information when completed.

HO File No.
Service No.(s)

AUTHORITY TO RELEASE MEDICAL INFORMATION

Patient's family name	Patient's given name(s)	Date of birth (y-m-d)
Address		

Name of doctor and/or hospital
Address

I hereby give permission for a representative of the Department of Veterans Affairs to have access to any records you may have on my file, as well as any special treatment record.

The information received will be collected under the authority of the *Pension Act* for the purpose of administering pension benefits. It will be protected by Canada's *Privacy Act* from disclosure to unauthorized persons and maintained in Personal Information Bank No. VAC/P-PU-055.

Patient's signature	Date	Home telephone No.
		Business telephone No.
Witness (if applicable)	Date	

Canada