Protected information when completed.

AUTHORITY TO RELEASE MEDICAL/SERVICE INFORMATION

HO File No.
Service No(s).

Family Name	Given Name(s)	Date of birth (y-m-d)

Address

Name of doctor, hospital and/or institution

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* or, if applicable, the *Canadian Forces Members and Veterans Re-establishment and Compensation Act,* after the coming into force of this legislation (expected as early as April 1, 2006) for the purpose of administering disability benefits. It will be protected by Canada's *Privacy Act* from disclosure to unauthorized persons. You may request a copy of this form by writing to the Access to Information and Privacy Coordinator's Office, Veterans Affairs Canada, P.O. Box 7700, Charlottetown, PE, C1A 8M9.

Client/applicant's signature Date	Home telephone No. Area code - -
	Business telephone No. Area code - - Extension -