OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

Department of Veterans Affairs

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE ENTIRE FORM (both pages) BEFORE SIGNING IN ITEM 11 BELOW.

SECTION I - RECORDS TO BE RELEASED TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of: All my medical records; including information related to my ability to perform tasks of daily living. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:
   a. Psychological, psychiatric, or other mental impairment(s) excluding "psychotherapy notes" as defined in 45 C.F.R. §164.501,
   b. Drug abuse, alcoholism, or other substance abuse,
   c. Sickle cell anemia,
   d. Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS,
   e. Gene-related impairments (including genetic test results).
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months after the date this authorization is signed in Item 11, as well as past information.

YOU SHOULD NOT COMPLETE THIS FORM UNLESS YOU WANT THE VA TO OBTAIN PRIVATE TREATMENT RECORDS ON YOUR BEHALF. IF YOU HAVE ALREADY PROVIDED THESE RECORDS OR INTEND TO OBTAIN THEM YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM. DOING SO WILL LENGTHEN YOUR CLAIM PROCESSING TIME.

IMPORTANT - In accordance with 38 C.F.R. §3.159(c), " VA will not pay any fees charged by a custodian to provide records requested."

SECTION II - VETERAN IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME (Type or print)	2. DATE OF BIRTH (MM,DD,YYYY)	3. SOCIAL SECURITY NUMBER/VA FILE NUMBER

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

4. LAST NAME - FIRST NAME - MIDDLE NAME (Type or print)	5. DATE OF BIRTH (MM,DD,YYYY)	6. SOCIAL SECURITY NUMBER
7. STREET ADDRESS	**8. CITY, STATE, ZIP CODE**	**9. TELEPHONE NUMBER** (Include Area Code)

SECTION IV - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

- ☐ ALL medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities,
- ☐ Social workers/rehabilitation counselors,
- ☐ Consulting examiners used by VA,
- ☐ Employers, insurance companies, workers' compensation programs, and
- ☐ Others who may know about my condition (family, neighbors, friends, public officials).

SECTION V - AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO VA AND SIGNATURE

10. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE (If this space is left blank, there is no limitation to records):

TO WHOM: The Department of Veterans Affairs (VA).
PURPOSE: Determining my eligibility for benefits, and whether I can manage such benefits.
EXPIRES: This authorization is good for 12 months from the date shown in Item 12.

- ☐ I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above in Section I.
- ☐ I understand that there are some circumstances in which this information may be re-disclosed to other parties (See page 2 for details).
- ☐ I may write to VA and my source(s) to revoke this authorization at any time (See page 2 for details).
- ☐ VA will give me a copy of this form, if I ask; I may also ask the source(s) to allow me to inspect or get a copy of material to be disclosed.
- ☐ I have read both pages of this form and agree to the disclosures above from the types of sources listed. See Patient Acknowledgement on Page 2.

11. SIGNATURE OF PERSON AUTHORIZING DISCLOSURE (Required)	12. DATE SIGNED (MM,DD,YYYY) (Required)
13. PRINTED NAME OF PERSON SIGNING (First, Middle Initial, Last)	**14. TELEPHONE NUMBER** (Include Area Code)

15. RELATIONSHIP TO VETERAN/CLAIMANT (If other than self, please provide full name, title, organization, city, State, and ZIP code. All court appointments must include docket number, county, and State)

NOTE: This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical and other information under P.L. 104-191 ("HIPAA"); 45 C.F.R. parts 160 and 164; 42 U.S.C. §290dd-2; 42 C.F.R. part 2, and State Law.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the source to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975 and still in effect.

If you do not revoke this authorization, it will automatically expire in 12 months from the date you sign and date the form. Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by VA without your consent if authorized by Federal laws such as the Privacy Act.

Under the Government Paperwork Elimination Act (GPEA) (Public Law 105-277), the Office of Management and Budget (OMB) ensures that agencies, when practicable, provide for the option of electronic maintenance, submission of disclosure of information and for the use and acceptance of electronic signatures. GPEA states that electronic records submitted or maintained in accordance with the procedures developed by OMB, or electronic signature or other forms of electronic authentication used in accordance with such procedures, "shall not be denied legal effect, validity, or enforceability merely because such records are in electronic form" (Public Law 105-277, section 1707).

RESPONDENT BURDEN: We need this information and your written authorization to obtain your treatment records to help us get the information required to process your claim. Title 38, United States Code, allows us to ask for this information. You can provide this authorization by signing VA Form 21-4142. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form. If you use the Telecommunications Device for the Deaf (TDD), the Federal relay number is 711.

PATIENT ACKNOWLEDGMENT: I HEREBY AUTHORIZE the sources listed in Section IV, to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the source being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it provides me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my source sends this information to VA 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 VA may disclose this information as authorized by law. I also understand that I may revoke this authorization in writing, at any time except to the extent a source of information has already relied on it to take an action. To revoke, I must send a written statement to the VA Regional Office handling my claim or the Board of Veterans' Appeals (if my claim is related to an appeal) and also send a copy directly to any of my sources that I no longer wish to disclose information about me. I understand that VA may use information disclosed prior to revocation to decide my claim.

NOTE: For additional information regarding VA Form 21-4142, refer to the following website:
www.benefits.va.gov/compensation/consent_privateproviders.asp.

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

Department of Veterans Affairs

GENERAL RELEASE FOR MEDICAL PROVIDER INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BELOW BEFORE COMPLETING THIS FORM.

INSTRUCTIONS - COMPLETE AND ATTACH THIS FORM WITH A SIGNED VA FORM 21-4142, AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA). IF YOU HAVE MORE THAN THREE PROVIDERS, FILL OUT ADDITIONAL COPIES OF THIS FORM, AVAILABLE AT WWW.VA.GOV/VAFORMS.

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN (Type or print)	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER

SECTION II - MEDICAL PROVIDER INFORMATION

4A. PROVIDER OR FACILITY NAME	4B. DATE(S) OF TREATMENT: (Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)
	From: To:
	From: To:

4C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
4D. CITY	4E. STATE AND ZIP CODE	4F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

5A. PROVIDER OR FACILITY NAME	5B. DATE(S) OF TREATMENT: (Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)
	From: To:
	From: To:

5C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
5D. CITY	5E. STATE AND ZIP CODE	5F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

6A. PROVIDER OR FACILITY NAME	6B. DATE(S) OF TREATMENT: (Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)
	From: To:
	From: To:

6C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
6D. CITY	6E. STATE AND ZIP CODE	6F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, and published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975 and still in effect.

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Veterans Angels Inc.

"Our tribute to those who have gone before, and our service to those who carry on"

501(c)(3)
Tax-Exempt
Public Charity in Nevada

EIN Number
27-0204290

In regard to completing VA form 21-2680:

The VA form must be signed by an MD or DO. The Department of Veterans affairs will not accept the signature of an RN or PA.

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Dear Physician;

Thank you for taking the time to complete the Medical Statement for Aid & Attendance. This is a DVA required Form. It will help determine the eligibility of your patient for a VA benefit. Completeness is very much appreciated.

* If applicable, The following wording needs to be written on Item # 25.
"Patient needs the Aid and Attendance of another person on a regular basis and is unable to protect themselves from the hazards of their daily environment."

* If the patient is residing in an Independent Living Facility:
Please write on Item # 25:
"Patient needs to reside in (Name of Facility) and receive Caregiver Services."

* Please provide to patient or authorized person 3-6 months of current medical records. DO NOT SEND TO VETERANS ANGELS, INC.

Thank you,
Linda Stone, Accredited Claims Agent, DVA
Veterans Angels, Inc.
1-888-319-1117
www.vetangels.org

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 5-31-2018

Department of Veterans Affairs

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

6. DATE OF EXAMINATION	7. HOME ADDRESS

8A. IS CLAIMANT HOSPITALIZED? ☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person.
The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable.
Findings should be recorded to show whether the claimant is blind or bedridden.
Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

11A. AGE	11B. SEX	12. WEIGHT ACTUAL: LBS. ESTIMATED: LBS.	13. HEIGHT FEET: INCHES:

14. NUTRITION	15. GAIT

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*

☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)* ☐ YES ☐ NO	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*

☐ YES ☐ NO

26. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*

☐ YES ☐ NO

28. POSTURE AND GENERAL APPEARANCE *(Attach a separate sheet of paper if additional space is needed)*

29. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE *(Attach a separate sheet of paper if additional space is needed)*

30. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

32. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

33. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

34. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐ YES

☐ NO *(If "YES," give distance) (Check applicable box or specify distance)* ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

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RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet pate at **http://www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.