# *VIRGINIA DEPARTMENT OF VETERANS SERVICES*

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

VDVS requests permission 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 unless the applicant and/or you can provide VDVS the necessary documents to make an eligibility determination on your dependent's request for VMSDEP.

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

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| **Veteran's Name** | Last Name | | First Name/MI | | |
| **SSN** | | | **DOB** | | |
| **Applicant's Name** | Last Name | | First Name/MI | | |
| **SSN** | | | **DOB** | | |
| **Applicant's Address** | | | | | |
| **City** | | **State** | | **ZIP** | |

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|---|---|---|---|---|---|
| **Applicant's Email** | | | | | |
| **Applicant's Home Phone** | ( ) - | **Best time to Call** | **AM** | **to** | **PM** |
| **Applicant's Cell Phone** | ( ) - | | | | |

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| **I give permission for VDVS to obtain information from the following VSO representative, agent, or attorney for VMSDEP processing:** | Please list your VSO representative, agent, or attorney. | Telephone # ( ) - |

**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***

***Signature:*** _____ ***Date:*** _____

**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 decide on my dependent's request for VMSDEP.

***VDVS USE ONLY:***

| **Document:** | **Date Received:** | **Staff:** | **Application Number:** |
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