



**DEPARTMENT OF VETERANS AFFAIRS**  
**Orlando VA Medical Center**  
**5201 Raymond Street**  
**Orlando, FL 32803**

675

Dear Veteran:

Please follow the instructions below to complete the enclosed 10-5345 for Release of Information.

**Field 1: TO: DEPARTMENT OF VETERANS AFFAIRS.** Includes the name and address of the Veterans Health Administration (VHA) facility providing the information.

**Field 2: PATIENT NAME.** Your last name, first name and middle initial if applicable.

**Field 3: SOCIAL SECURITY NUMBER (SSN).** SSN is required to ensure your correct identification in order to provide the accurate information.

**Field 4: NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM THE INFORMATION IS TO BE RELEASED.** Must be completed fully with sufficient information to ensure the records reach the intended recipient.

**Field 5: VETERAN'S REQUEST.** This box is completed ONLY if the request includes information on one of the four identified conditions covered in 38 U.S.C. § 7332. If the information released does not include any of these specific conditions, or if you do not have any such information in your file; you do NOT complete this field.

**Field 6: INFORMATION REQUESTED.** You must choose from the two specific options provided or "other". The text box must be completed in all cases to specify the request as much as possible.

**Field 7: PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY THE INDIVIDUAL TO WHOM THE INFORMATION IS TO BE RELEASED.** Examples of simple purposes include: personal, treatment, payment and life insurance.

**Field 8: AUTHORIZATION.** The language in the form contains two of the three "required statements" from the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, provides important information to you, and is where the required expiration information is located. If any boxes are selected for 7332-protected information (see Field 5), a date MUST be provided in "option 2" (date supplied by patient) of this field.

**Field 9: DATE.** The date the form was signed. It is the date in which the authorization becomes effective.

**Field 10: SIGNATURE.** The Veteran must sign the form to complete the request.

Sincerely yours,