Submission of Documents to Department Of Veterans Affairs Centralized Mail Processing (CMP)

☐ **Evidence Intake Center**
PO Box 4444 or Box 5235
Newnan, Georgia
30271-0020
FAX 1-844-531-7818
or 1-248-524-4260

☐ **Evidence Intake Center**
PO Box 4444
Janesville, WI
53547-4444
FAX 1-844-822-5246
or 1-608-373-6690

Veteran:
C-File or SSN:
Street Address:
City, State, Zip:

Date:

From:	**Name and Relationship to Veteran**
	Title
	Address
	City, State, Zip
Tel:	**Fax**
	Email:

Type of Document Submitted:

☐Evidence on Behalf of Veteran/Dependent Named above:
☐Appeal on Behalf of Veteran/Dependent Named above
☐Inquiry on Status of Case
☐Waiver
☐Freedom of Information Act
☐Privacy Act
☐Dependency
☑Other (See below):
Request for Veteran's Entire C-File of ALL pages in (1) paper form or (2) on digital media CD/DVD containing Adobe Acrobat PDF Format.

Number of Pages Submitted (NOT including this cover sheet):	**TWO**

☑ ☒ ☑

OMB Control No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: 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 required to obtain or retain benefits. 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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 Page at **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.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

PRIVACY ACT WAIVER AND REQUEST FOR ENTIRE "C" FILE AND SQC INFORMATION

By my signature below, I authorize the following person: _____
ADDRESS: _____
to have access to all of my VA records.

This **includes** access to any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV) , or sickle cell anemia, that may be or are contained or maintained in my VA Claimant records.

Redisclosure of the information or records relating to the conditions named in the second paragraph above by my attorney other than to VA or the Court of Veterans Appeals is not authorized without my further written consent. This authorization pertaining to the information or records listed in the second paragraph above, will remain in effect until records listed in the second paragraph above, will remain in effect until the earlier of the following two events: **(1)** I specifically revoke this authorization by the filing of a written revocation which will be effective except to the extent that action has been taken in reliance upon the authorization, or, **(2)** disclosure of the aforementioned information or records is no longer necessary for benefits determination purposes.

My consent for the disclosure of information relating to the condition of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia, that may be or are contained or maintained in VA Claimant records pertaining to. me, is limited as follows: **NOT LIMITED**

In order to waive my rights under the Privacy Act, 5 U.S.C. 552a(b), and under any other federal or state law or regulation which controls access to my records, I give my prior written consent to the National Personnel Records Center (Military Personnel records), St. Louis, Missouri; to the Department Of Veterans Affairs; to the Department of Health and Human Services; Social Security Administration; or any other public or private Custodian of (including, but not limited to, hospitals, Clinics, and current and former treating physicians), or agency that possesses or controls my military, veteran, medical, mental, Sickle Cell Anemia, infection with Human Immunodeficiency Virus (HIV), drug or alcohol treatment, Discharge Review or Correction Board records and files, to disclose fully and promptly to the person named above, his agents, or to any other person designated by this person, any and all records contained in my file which I or any other person designated may request. This authorization does not constitute a Power of Attorney or Retainer or any other form of agreement which would require someone represent me.

I also request documentation of any **SQC review** of my DVA files by any subdivision of the DVA showing the form of review problems identified, and/or any corrective or other action taken by the Regional Office or the Central Office of the DVA.

I also make this request under the Freedom of Information Act.

I want all pages of my C-FILE either sent to the person named above or to me personally either as (1) paper files or as (2) Adobe Acrobat PDF format on digital media such as a CD or DVD. If any request for my C-File was previously granted, I want all updated pages since that previous request was sent to include all pages dated after the latest date of any previous C-File page.

If represented, I state that my Attorney or Representative is _____
ADDRESS: _____

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

The following statement is made in connection with a claim for benefits in the case of the above-named veteran: