

## DEPARTMENT OF VETERAN AFFAIRS

RELEASE OF INFORMATION WAIVER			
1. NAME OF BENEFICIARY (FIRST, MIDDLE, LAST)	2. VA FILE NUMBER	3. SOCIAL SECURITY NO	4. DATE OF BIRTH
5. NAME AND ADDRESS OF AGENCY INFORMATION IS TO BE RELEASED TO:			
WYOMING DEPT. OF HEALTH ATTN: TAX REFUND FOR ELDERLY & DISABLED PROGRAM 460 HATHAWAY BUILDING CHEYENNE, WY 82002-0710			
I, THE UNDERSIGNED, HEREBY AUTHORIZE THE DEPARTMENT OF VETERANS AFFAIRS TO			
RELEASE TO THE DEPARTMENT OF HEALTH ANY AND ALL INFORMATION RELATING TO MY			
VA BENEFITS. THE RESPONSES WHICH ARE SUBMITTED MAY BE DISCLOSED OUTSIDE THE			
DEPARTMENT OF VETERANS AFFAIRS ONLY AS PERMITTED BY LAW.			
6. SIGNATURE OF DEPARTMENT OF VETERANS AF	7. DATE SIG	NED	
CHECK BELOW			
CHECK MARK THIS BOX IF YOU RECEIVE MEDICAL			

2011 MONTHLY BENEFITS THAT YOU RECEIVED FROM 01-01-2011 TO 12-31-2011 WERE: \$\_\_\_\_\_. PLEASE

INCLUDE DOCUMENTATION OF YOUR VA BENEFIT.

**BENEFITS ONLY!**