



APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER <i>(Include prefix)</i>
3. NAME ONLY OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS <i>(See list on reverse side before selecting organization)</i>	

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER	5. INSURANCE NUMBER(S) <i>(Include letter prefix)</i>		
6A. SERVICE NUMBER(S)	6B. BRANCH OF SERVICE		
7. NAME OF CLAIMANT <i>(If other than veteran)</i>	8. RELATIONSHIP <i>(If other than veteran)</i>		
9. ADDRESS OF CLAIMANT <i>(No. and street or rural route, city or P.O., State and ZIP Code)</i>	10. CLAIMANT'S TELEPHONE NUMBER <i>(Include Area Code)</i>		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. DAYTIME ()</td> <td style="width: 50%; padding: 2px;">B. EVENING ()</td> </tr> </table>	A. DAYTIME ()	B. EVENING ()
A. DAYTIME ()	B. EVENING ()		
11. DATE OF THIS APPOINTMENT			

NOTE: Complete Item 12 only if claim filed for disability insurance benefits.

12. TYPE OF DISABILITY INSURANCE BENEFITS FILED FOR

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13. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I **do not authorize** VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

I authorize the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 3 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named above, either by explicit revocation or the appointment of another representative.

14. LIMITATION OF CONSENT. My consent in Item 13 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

I, the claimant named in Items 1 or 7, hereby appoint the service organization named in Item 3 as my representative to prepare, present and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 1. I authorize the Department of Veterans Affairs to release any and all of my records *(other than as provided in Items 13 and 14)* to that service organization appointed as my representative. It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney. I understand that the service organization I have appointed as my representative may revoke this power of attorney at any time, subject to 38 C.F.R. § 20.608. Signed and accepted subject to the foregoing conditions.

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

15. SIGNATURE OF CLAIMANT (Do Not Print)	16. DATE SIGNED
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VA USE ONLY	VA FORM 21-22-1 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)	REVOKED <i>(Reason and date)</i>
	<input type="checkbox"/> CER FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> INSURANCE FILE <input type="checkbox"/> CH. 30 <input type="checkbox"/> DEA FILE <input type="checkbox"/> LG FILE			

NOTE: As long as this appointment is in effect the organization named herein will be recognized as the sole agent for presentation of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.