AUTHORIZATION FOR CONSENT TO RELEASE INFORMATION TO A THIRD PARTY

State Form 56820 (8-19)

INDIANA DEPARTMENT OF VETERANS AFFAIRS
302 West Washington Street, Room E120
Indianapolis, Indiana 46204-2738
Telephone: (317) 232-3910
Toll-Free: (800) 400-4520
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Website: www.in.gov/dva

I _____, hereby authorize the Indiana Department of Veterans' Affairs to disclose information pertaining to my application for benefits to the third party that is listed on this form. I fully release the Indiana Department of Veterans' Affairs to disclose any and all information related to my benefits application including, but not limited to, personal information. I agree to willingly provide any information required to assist in this process.
I understand that the Indiana Department of Veterans' Affairs will not disclose my information to any party other than the one(s) listed on this form.

PERSON OR ORGANIZATION TO WHOM THE INDIANA DEPARTMENT OF VETERANS' AFFAIRS MAY DISCLOSE MY INFORMATION	
Name of person or organization	**Relationship**

Authorized signature	Date *(month, day, year)*
Printed name	
Authorized signature	Date *(month, day, year)*
Printed name	

For Official Use Only	
Date received *(month, day, year)*	Received by: