C-File Request Form for VA Claims File is below:
TO: Veteran Official in Charge of C-File
Department of Veterans Affairs,Regional Office
(Use your Regional Office as in the example below)
251 North Main Street, Winston Salem, NC 27155

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

Veteran' s Printed Name: _____
VA File Number and Social Security number: _____
By my signature below, I authorize _____
whose address is _____
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.

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

_____ _____
VETERAN'S SIGNATURE Date

_____
VETERAN'S ADDRESS, CITY, STATE AND ZIP