



**For NGND-G1 Internal Use Only:**

	Initials	Date
Received		
Completed		
Mailed/Faxed/Other _____ (circle all that apply)		

**AUTHORIZATION FOR RELEASE OF INFORMATION**  
 (Please ensure all lines are completed. Non answered lines may delay response time.)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

Maiden/Other Name \_\_\_\_\_ SSN \_\_\_\_\_ SN \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Branch of Military: \_\_\_\_\_ AD/NG/Res \_\_\_\_\_ Dates of Service: \_\_\_\_\_ Rank: \_\_\_\_\_  
(Circle one)

I hereby authorize North Dakota Army National Guard ATTN: NGND-G1-MPA, P.O. Box 5511,  
Bismarck, ND 58506-5511 FAX: 701-333-3082

To release to: \_\_\_\_\_  
Full Name of person/facility to receive information

Release by: Mail \_\_\_\_\_  
Address of person/facility to receive information and Telephone Number

Fax: \_\_\_\_\_  
Fax number of person/facility to receive information and Telephone Number

Email Address: \_\_\_\_\_  
Email Address of person/facility to receive information and Telephone Number

**The following information:**

\_\_\_\_\_ DD Form 214 (Active Duty discharge) \_\_\_\_\_ NGB Form 22 (NG discharge)  
 \_\_\_\_\_ NGB Form 23 (Retirement History) \_\_\_\_\_ Medical documentation dated/related to:  
 \_\_\_\_\_ Other: (Specify below)

**Reason for Request:**

**Requestor's Consent:**

This authorization is voluntary and remains in effect unless specifically revoked by written notice to the facility or person or expires on \_\_\_\_\_. If an expiration date is not entered, authorization will expire one year from date of signature. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule. A photocopy of this release is as effective as the original. If Power of Attorney is used, a copy of Power of Attorney must accompany the request. Requested document(s) may contain Personally Identifiable Information such as name, address or social security number. I authorize the sender to transmit these documents to me as identified above.

Signature of Person or Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_  
Meets requirements of Health Insurance Portability and Accountability Act of 1996 (PL 104-191)

**Send completed form(s) to:**

North Dakota Army National Guard, ATTN: NGND-G1-MPA, P.O. Box 5511, Bismarck, ND 58506-5511  
 NDTAA FORM ROI Dated 19 September 2018 (Previous Editions are Obsolete)