

**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 ZipBranch 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,
Name person/facilityBismarck, ND 58506-5511 FAX: 701-333-3082
Address of person/facilityTo release to: _____
Name of person/facility to receive information_____
Address of person/facility to receive information_____
Telephone: FAX:**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)**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 request.

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 1 September 2014 (Previous Editions are Obsolete)