Department of Veterans Affairs

POWER OF ATTORNEY AND ASSIGNMENT

I hereby assign to the Department of Veterans Affairs any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the Department of Veterans Affairs. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the Department of Veterans Affairs or any other amount to which I may be entitled.

I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned.

I hereby authorize the Department of Veterans Affairs to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the Department of Veterans Affairs any information regarding my claim.

NAME OF PATIENT *(Please print clearly)*			
SIGNATURE OF PATIENT	DATE	SIGNATURE OF WITNESS	DATE

VA FORM JUN 2008 **4763**

EXISTING STOCK OF VA FORM 4763, APR 1993, MAY BE USED.

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