VIRGINIA VICTIMS FUND
Helping Innocent Victims of Crime
OFFICIALLY CRIMINAL INJURIES COMPENSATION FUND

Permission for Verbal Communications

A Division of the Virginia Workers' Compensation Commission

virginiavictimsfund.org Mail: P.O. Box 26927, Richmond Virginia 23261 Phone: 800-552-4007 Fax: 804-823-6905

Instructions: Please complete, sign and return to the Virginia Victims Fund.

Print Name of Claimant

VVF Claim Number (If Known)

Street Address

City, State, Zip Code

Phone Number of Claimant

Date of Birth

Last Four of Social Security Number (SSN)

I permit Virginia Victims Fund staff to discuss information related to the above-named claim, in person or by telephone, with staff members of _____ ,
(Name of Organization)

who is assisting me with completing my Virginia Victims Fund (VVF) claim.

I permit Virginia Victims Fund staff to discuss information related to the above-named claim, in person or by telephone, with the following designated family members who are assisting me with my VVF claim:

Name	Phone Number	Relationship	Date of Birth

Release of information under this document is limited to verbal communication with Virginia Victims Fund staff. This document does not permit the release of any written information to the organization/individuals listed above.

This authorization is limited to the timeframe from _____ (date) to _____ (date). If no dates are specified, this form will remain in effect for an unlimited period of time.

This authorization is further limited to discussions regarding the following:

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the claimant has received care.)

Claimant/Applicant Signature

Date