



U.S. DEPARTMENT of STATE

Bureau of Medical Services

Privacy Act Statement

AUTHORITY: The information on this form is sought pursuant to 22 U.S.C §4084 and 5 U.S.C. §552a(b).

PURPOSE: The information solicited on this form will be used to provide all paper and electronic medical records as requested.

ROUTINE USES: The information on this form may be shared with the requester or person authorized by the requester. The information may also be made available to a health oversight agency for activities such as audits, investigations, and inspections. More information on the Routine Uses for the system can be found in the System of Records Notice, State SORN #24, Medical Records.

DISCLOSURE: Providing this information is voluntary. Failure to provide the information requested on this form may result in a lack of records release.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION			
This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Department of State Bureau of Medical Services Health Information Management to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Department of State Bureau of Medical Services. Revoking this authorization will not affect any action taken prior to receipt of your written request.			
Section A. Personal Information: (individual whose information will be released)			
Name: (Last, First, Middle)		Date of Birth:	
Address: (include zip code)		Place of Birth:	Telephone:
			E-Mail:
Section B. Recipient: (person or organization that will receive your information)			
Name:	Organization:	Telephone: (include area code)	Fax Number:
Address: (include zip code)		Government E-Mail:	Private E-Mail:
Section C. Description of the Information to be Released: (what type of information will be released)			
<input type="checkbox"/> Last Physical Exam Only <input type="checkbox"/> Last Three Years <input type="checkbox"/> All Records on File			
<input type="checkbox"/> Specific Document (Please Specify): _____			
Section D. Authorization Expiration:			
This authorization will expire (Check ONLY ONE box):			
<input type="checkbox"/> For One Time Use Only			
<input type="checkbox"/> On Date: (mm/dd/yyyy) ____/____/____			
NOTE: If no date identified, the default date of ONE year from the date your form is received will be used.			
Section E. Approval: (You or your Personal Representative MUST sign and date this form in order for it to be complete.)			
I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.			
Requestor Signature: By signing below, I authorize the release of my protected health information as described above.			
(Signature)	(Print Name)	(Date)	(Relationship) Self Child Custodial Parent Other:
Note: Spouses do not have access to medical records without written permission. Records of a dependent minor will ONLY be released to custodial parent(s). By signing this form, the requesting parent affirms that he or she is a custodial parent.			
Submission:		Mail: Department of State Bureau of Medical Services 2401 E St NW, Washington, DC 20522 Attn: Medical Records Fax: 202-647-0292 E-Mail: MEDMR@state.gov	