United States Department of State
Office of Medical Services
Health Information Management
Washington, D.C. 20520

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 Office 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 Office 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, Full Middle)	Date of Birth: (Month/Day/Year)
Address: (including zip code)	Telephone: (including area code)
	E-Mail:

Section B. Recipient: (person or organization that will receive your information)

Person's Name or Organization:	Telephone: (including area code)	Fax Number
Address: (including zip code)	☐ Government E-Mail: _____ ☐ Private E-Mail: _____	

Section C. Description of the Information to be Released: (what type of information will be released)

☐ Last Physical Exam Only
☐ Specific Document (specify): _____
☐ Last Three Years
☐ All Records on File

Purpose of Release: _____

Section D. Expiration: (when this authorization will end)**

This authorization will expire (Check ONLY ONE box):
☐ When I revoke this authorization*
☐ Upon the following date or event*:_____
* The Department of State Office of Medical Servicers must be notified in writing of the event to cancel or revoke this authorization.
NOTE: If you do not indicate an expiration date or event, the default date of ONE year from the date we received your form 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.

	(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 | Office of Medical Services | 2401 E St NW, Washington, DC 20522 | Attn: Medical Records
	Fax: 703-845-4850
	E-Mail: MedMR@state.gov

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2211	0	6/3/06	RGB	CAG	
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