

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Pursuant to the Privacy Act of 1974, 5 U.S.C. 552a, 29 CFR 1910, 1920, and 42 CFR Part2)

DECLARATION I hereby authorize the release of information from my medical records.	AUTHORIZATION DATE	EXPIRATION DATE (+90 days)
NAME of OFFICER (Last, First Middle)	DATE of BIRTH	EMPLOYEE IDENTIFICATION #
RELEASE RECORDS TO:	RECORDS RELEASED FROM:	

Release the following records and information:

- ☐ All records (including information pertaining to HIV results, drug and/or alcohol abuse, mental health, and communicable diseases)
- ☐ Diagnostic image testing reports, including x-rays, mammograms, and ultra-sounds
- ☐ Films of mammograms and ultra-sounds
- ☐ Hospital discharge summaries
- ☐ Operative reports
- ☐ Laboratory results
- ☐ Other (Specify)

I understand that the information released is to the specific recipient stated above. Any other disclosure of this information without my written consent is prohibited. I further understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. This consent will expire 90 days after the date of my signature unless specified otherwise.

Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor and fined not more than \$5,000 (5 U.S.C. 552a (i)(3)). In the case of alcohol and drug abuse patient records, a falsified authorization for disclosure is prohibited under 42 CFR 2.31 and is punishable by a fine of not more than \$500 for a first offense or a fine of not more than \$5,000 for a subsequent offense, in accordance with 42 CFR 2.4.

I declare, under penalty of perjury, that I am the person to whom the relevant medical records pertain. (Notarized signature may substitute for this declaration)

OFFICER SIGNATURE	SIGNATURE DATE
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