OMB Control Number: 0915-0334
Expiration Date: 9/30/2013

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. PATIENT IDENTIFICATION *(Injured Countermeasure Recipient)*		
NAME (*Last)*	*(First)*	*(MI)*
ADDRESS		
CITY/STATE/ZIPCODE	DATE OF BIRTH	

II. **I, _____, or _____**
(Name of Patient) ***(Name of Parent or Representative)***
authorize the disclosure of the above named individual's health records.

III. The information is to be disclosed by:	And is to be provided to:
Name of Facility/Provider	U.S. Department of Health and Human Services Health Resources and Services Administration Countermeasures Injury Compensation Program 5600 Fishers Lane, Room 11C-06 Rockville, MD 20857
Address	
City/State/Zip Code	

IV. The purpose or need for this disclosure is to apply for benefits with the U.S. Department of Health and Human Services, Health Resources and Services Administration, Countermeasures Injury Compensation Program (CICP). In some instances the information may be used for certain medical research purposes when consistent with the purposes for which the CICP was formed, e.g., gathering data regarding countermeasures adverse events.

V. The information to be disclosed from the above named individual's health record *(check appropriate box(es).*

☐ Entire record from _____ to the present *(see instructions for appropriate date)*

☐ Only information related to *(specify)*_____

☐ Other *(specify*, e.g., insurance coverage, billing, etc.)_____

VI. I understand that I may revoke this authorization in writing at any time to the Health Information Management (Health Records) Department of my facility/provider, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____
(Enter if different from one year after date below)

VII. SIGNATURE OF PATIENT	DATE
SIGNATURE OF PERSONAL REPRESENTATIVE (state relationship to patient, e.g., parent) or WITNESS (if signature is thumbprint or mark)	DATE

This information is to be released for the purposes stated above and may not be used by the recipient for any other purpose.

VIII. FOR OFFICIAL CICP USE ONLY
CICP No. _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

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PRIVACY ACT STATEMENT

Section 319F-4 of the Public Health Service Act (PHS Act), Public Law 109-148 (42 U.S.C. 247d-6e), and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive benefits. This information will be disclosed to the U.S. Department of Health and Human Services and its consultants; and Federal, State, or local law enforcement agencies, if the Government becomes aware of a possible violation of civil or criminal law; and for certain medical research purposes when consistent with the purposes for which the Program was formed, i.e., to make determinations concerning alleged covered countermeasure injury associations and to provide compensation to individuals injured by covered countermeasures. Furnishing the information on this Form, including the social security number, is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act, 5 USC Section 552a, as amended.

PUBLIC BURDEN STATEMENT

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0334. Public reporting burden for this collection of information is estimated to average 5 hours per respondent annually, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857

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Instructions for Completing HRSA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Type or print legibly in all fields using dark ink.

Section I – Provide the name, address, and date of birth of the injured countermeasure recipient.

Section II – Provide the name of the person authorizing the information to be released.

Section III – Provide the name and address of the facility or provider releasing the information. This is the facility or provider of health care services to the injured countermeasure recipient.

Section V – Check the appropriate box as applicable. The CICP will provide direction as to which records are needed.

1. **Entire Record – the complete record from the identified facility or provider from one (1) year prior to administration or use of the covered countermeasure that may have caused the injury. Please enter this date.**
2. **Only information related to – specify diagnosis, injury, operations special therapies, etc. within a specific date range. (Only complete this section if instructed to do so by the CICP).**
3. **Other (specify) – e.g., insurance coverage, billing, etc. (Only complete this section if instructed to do so by the CICP).**

Section VI – The requester may revoke this authorization at any time by notifying the Health Information Management (Health Records) Department of the facility/provider in Section III, in writing. If a different expiration date is desired, specify a new date. You may consider providing a date longer than one year if you have an ongoing CICP covered injury that has not resolved or may not be resolved soon.

Section VII – Patient (i.e., the injured countermeasure recipient) or personal representative (e.g., parent, legal guardian, power of attorney etc.) must sign and date.

Send a copy of the completed form to the facility/provider identified, and, **at the same time, also mail or fax a copy of the completed form to the CICP at the address below:**

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, Room 11C-06
Rockville, MD 20857
Fax: (301) 443-0704

If you have questions contact the CICP at:

1-888-ASK-HRSA (1-888-275-4772); or
www.hrsa.gov/countermeasurescomp