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

PLEASE COMPLETE ALL APPLICABLE SECTIONS, SIGN, AND DATE

I. PATIENT IDENTIFICATION *(Injured Countermeasure Recipient)*	***FOR OFFICIAL CICP USE ONLY*** **CICP No.** _____	
NAME *(Last)*	*(First)*	*(MI)*
ADDRESS		
CITY/STATE/ZIPCODE	DATE OF BIRTH	

II. _____
Personal Representative, if applicable, for injured countermeasure recipient/ patient in section I
(e.g. parent of a minor or guardian, administrator for estate)

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 information to be disclosed from the patient's, as identified in section I, health record *(check appropriate box(es)).*

☐ Entire medical records from _____ to the present *(see instructions for appropriate date)*
☐ Only information (e.g. medical records) related to *(specify injury or cause of death)*_____
☐ Other *(specify,* e.g., insurance coverage, billing, etc.) _____

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

V. I understand that I may revoke this authorization in writing at any time by contacting 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.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 Date of Termination or Expiration if different from one year after date below)

VI. SIGNATURE OF PATIENT	DATE
VII. SIGNATURE OF PERSONAL REPRESENTATIVE (if applicable)	DATE
VIII. SIGNATURE OF WITNESS (if signature is thumbprint or mark, or if required by State law)	DATE

Consenting to this authorization of disclosure of records is voluntary and health provider(s) shall not condition treatment upon the individual's signature of such authorization for use or disclosure of health information. This information is subject to release for the purposes stated in Section IV and may not be used by the recipient for any other purpose unless permitted by federal law. I understand that information disclosed by this authorization, except for alcohol and drug abuse patient records as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a).