AUTHORIZATION FOR PEACE CORPS USE OF MEDICAL INFORMATION

This authorization permits the Peace Corps to use my protected health information to determine my eligibility for the Peace Corps and as necessary for administration of the Peace Corps program. Without a signed Authorization, the Peace Corps cannot process my application.

I, _____, hereby authorize that:
(Please print or type name)

A. All health information I provide to the Peace Corps or that is provided by anyone who has provided health care services or treatment to me, consulted on such services, or otherwise has health care information responsive to the information requests of the Peace Corps, including my response to the Health Status Review, and any follow-up health information requested by and provided to the Peace Corps Office of Medical Services relating to me prior to my being sworn in as a Peace Corps Volunteer (including but not limited to information about my prior physical and mental health history, my current health status, and possible future care and treatment), may be disclosed to the following people:

   Peace Corps staff, including in the Office of Medical Services, Office of Special Services, Office of Volunteer Recruitment and Selection, Office of Safety and Security, Office of General Counsel, appropriate Regional Operations offices, Peace Corps Medical Officers, Country Directors at overseas posts, and any other Peace Corps staff or contractors who have a need to know the information to perform their duties, for the purposes of making a determination of my medical or other eligibility for Peace Corps service and of placement/assignment.

B. If I am accepted for Peace Corps service, the information listed above will become part of my Peace Corps health record. All information in my Peace Corps health record, and any other personal health information relevant to me that is provided to the Peace Corps by me or any health care provider or other person, may be disclosed to Peace Corps staff or contractors, as described in paragraph A above, who have a specific need to know the information for the purposes of performing their duties in connection with administration of the Peace Corps program only. This may include (but is not limited to) information relevant to my continued service as a Peace Corps trainee or Peace Corps Volunteer.

   This authorization is effective until five years following either my close of Peace Corps service or final determination by the Peace Corps that I am not eligible for Peace Corps service. I understand that I may revoke this authorization at any time by sending a

   written revocation to the Office of Medical Services, Peace Corps, Paul D. Coverdell Peace Corps Headquarters, 1111 20th Street, NW, Washington DC, 20526, but that my revocation before acceptance will stop consideration of my application, and that my service as a Volunteer is conditioned on the existence of this authorization, which is necessary to administer the Peace Corps program.

I understand that Peace Corps will carefully protect the confidentiality of my health care information for the duration of the authorization period, consistent with the Privacy Act, the Health Insurance Portability and Accountability Act (as applicable), and Peace Corps policies on confidentiality of medical information, as described in the Peace Corps Notice of Privacy Practices.

I have read and understand this authorization.

Printed Name	Signature
Date (m/d/yr)	DOB