AUTHORIZATION TO PERMIT DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ [*print name*] hereby authorize the disclosure by the Peace Corps to:

[*name and contact information of permitted recipient(s), e.g., parents, staff in the Office of the Honorable _____ , other Peace Corps staff members , other Volunteers*]

of the following information:

(Description of information requested (e.g., information in my Peace Corps medical records; specific portions of or information in your medical record.. If you want different information to go to different individuals, please prepare a separate form for each recipient.)

This disclosure is at my request. I understand that the information disclosed pursuant to this consent is subject to redisclosure by the recipient(s), which may result in the loss of Privacy Act or Health Insurance Portability and Accountability Act (HIPAA) protections. This consent is effective until _____. I understand that I may also revoke this consent in writing at any time.

_____

Signature *Date*