PEACE CORPS

Office of Health Services

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: To be completed by the (Returned) Volunteer.

Send completed forms to: medrecords@peacecorps.gov or Fax: 202.692.1577 ATTN: Med Records

COMPLETE ALL SECTIONS, DATE AND SIGN

1. Patient Name: _____ Volunteer ID (if known):_____
   Date of Birth _____/_____/_____ (mm/dd/yyyy)
   Address: _____ City: _____ State: _____ Zip Code: _____
   Email Address: _____ Phone: _____

2. I request that my protected health information (PHI) from the Peace Corps be disclosed to:

Recipient Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

3. The purpose or need for this disclosure is:

☐ Continuing Care ☐ Personal Use ☐ School ☐ Other (Specify) _____

4. I authorize the following PHI to be released from my medical records:

☐ All Records ☐ Immunization Records ☐ Dental Records
☐ Pre-Service Health Records ☐ In-Service Health Records ☐ Post Service Health Records
☐ Consultant Reports ☐ Sexual Assault Records

I understand that the information in my medical record may include information related to sexually transmitted diseases including HIV/AIDS. It may also include information about behavioral and mental health services and/ or alcohol and drug abuse treatment. I agree to have the following information released:

Sexually Transmitted Infections: ◯ Yes ◯ No Mental Health Information: ◯ Yes ◯ No
Substance Abuse/Treatment (Drug/Alcohol): ◯ Yes ◯ No HIV/AIDS Information: ◯ Yes ◯ No

Term: I understand that this Authorization will remain in effect:

From the date of this Authorization until _____/_____/_____ (mm/dd/yyyy)

Redisclosure: I understand that Peace Corps cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services from the Peace Corps healthcare facilities. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Office of Inspector General at the address listed below. The revocation will be effective immediately upon my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this authorization before it received my written notice of revocation.

Signature of Patient or Personal Representative (State Relationship to Patient)	Date
Signature of Witness (Signature required only if Personal Rep. is signing)	Date