

Authorization For Release of Medical Information (Black Lung Benefits)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation



This report is authorized by law (30 U.S.C., 901 at. seq.). While you are not required to respond, your cooperation is needed to ensure that your claim is given full and proper consideration. Disclosure of a social security number is voluntary. The failure to disclose such number will not result in the denial of any right, benefit, or privilege to which you may be entitled.

OMB No. 1215-0057
Expires: 11-30-06

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|--|-----------------------------------|
| 1. Miner's Name | 2. Miner's Social Security Number |
| 3. Claimant's Name | 4. Relationship to Miner |
| 5. Address (Street Number, City, State & ZIP Code) | 6. Phone Number |

I hereby authorize any physician, hospital, agency, or other organization, including the National Institute of Occupational Safety and Health, (NIOSH), Appalachian Laboratory for Occupational Safety and Health (ALOSH), to disclose to the Office of Workers' Compensation Programs of the U.S. Department of Labor any medical records or other information about (my) or (the deceased miner's) medical condition for the purpose of providing evidence related to my claim for benefits under the Black Lung Benefits Act.

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| 7. Signature of Claimant (or person on his behalf) | 8. Date (Month, day, year) |
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Identifying Information for Hospitals

| Admission Date(s) | Discharge Date(s) | Birth Date |
|----------------------|-------------------|------------|
| | | |

Give any necessary additional identifying data (such as building, clinic, patient number, etc.)

- In-patient
- Out-patient

Miner's address at time of hospitalization

Other:

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including 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 the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room N3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

PRIVACY ACT

The following information is provided in accordance with the Privacy Act of 1974. (1) Collection of this information is authorized by the Black Lung Benefits Act, as amended (30 USC 901 et seq.), and 20 CFR 725.405. (2) The information in this form will be used to request medical information pertinent to the black lung claim. Disclosure of beneficiary's social security number and completion of this form are voluntary. Failure to provide the requested release of medical documentation may exclude relevant medical information from consideration in the black lung claim. (3) Information may be used by other agencies, government contractors or persons in handling matters related, directly or indirectly, to processing this form. (4) Furnishing all requested information will facilitate accurate and timely processing of the black lung claim.