AUTHORIZATION TO RELEASE INFORMATION FORM

NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM

_____,
(Print Name – First, Middle, Last)

As a National Health Service Corps (NHSC) Loan Repayment Program (LRP) applicant, I hereby authorize:

1. The United States Department of Health and Human Services (HHS), and/or its contractors, to release the following information to a consumer reporting agency (credit bureau) to obtain a credit report to assess my eligibility, creditworthiness and suitability to participate in the NHSC LRP and to verify my educational loans: my name, address(es), social security number, and other information necessary to identify me.

2. The HHS, and/or its contractors, to release the following information to the lenders/holders of my educational loans in order to obtain loan payoff balances, to determine my eligibility/qualifications to participate in the NHSC LRP, and to determine the eligibility of my educational loans for repayment under the NHSC LRP: my name, address(es), social security number, account number(s), account status, and other information necessary to identify me.

3. The HHS, and/or its contractors, to release my name, address(es) and social security number for the purpose of determining whether I appear on the Excluded Parties System List.

4. The HHS, and/or its contractors, to release my name, address(es) and social security number for the purpose of obtaining the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank Reports to assess my professional competence and conduct.

5. Any program to which I owe a service obligation to release information relating to that obligation to HHS and/or its contractors.

This authorization will take effect on the date that I sign this release form. If I become a participant in the NHSC Loan Repayment Program, this authorization shall remain in effect until the date my NHSC Loan Repayment Program obligation, including any extension of the obligation pursuant to contract extensions and amendments, has been fulfilled. If I do not become a participant in the NHSC Loan Repayment Program, this authorization shall remain in effect until ***September 30, 2011***. The authorization may be revoked by me in writing at any time.

_____ _____
(Signature of Applicant) ***(Date)***

_____
(Please Print Name)

(Revised 05/09 – DAA, BCRS, HRSA, DHHS)

PRIVACY ACT RELEASE AUTHORIZATION FORM

NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM

I, _____, residing at _____
_____, am an applicant to the National Health Service Corps (NHSC) Loan Repayment Program (42 U.S.C. 254l-1). I hereby authorize the Department of Health and Human Services, and/or its contractors, to disclose any information contained in its files relating to my application to participate in the NHSC Loan Repayment Program **to**:

_____ _____
(Individual) **(Relationship / Name of Firm)**

_____
(Address)

_____
(City, State, Zip Code)

This authority shall remain in effect until ***September 30, 2011***, or until this authorization is revoked by me in writing, whichever occurs first.

I certify that I am the above-named applicant. I understand that the knowing and willful request for, or acquisition of, information pertaining to an individual from an agency under false pretenses is a criminal offense under the Privacy Act, subject to a $5,000 fine (5 U.S.C. 552a(i)(3)).

_____ _____
(Signature of Applicant) **(Date)**

I certify that I am the above-named individual, to whom the applicant has authorized disclosure. I understand that the knowing and willful request for, or acquisition of, information pertaining to an individual from an agency under false pretenses is a criminal offense under the Privacy Act, subject to a $5,000 fine (5 U.S.C. 552a(i)(3)).

_____ _____
(Signature of Individual) **(Date)**